Board of Local and Regional Jails
Calendar Year 2024
Annual Report of Jail Death Reviews

JULY 1, 2025

CONTENTS

PURPOSE

Pursuant to the Code of Virginia §53.1-69.1, the Board of Local and Regional Jails (BLRJ) is statutorily directed to annually report to the General Assembly and the Governor.

Code of Virginia §53.1-69.1. (E.)

The Board shall publish an annual report that includes the following: (i) a summary of the reviews of the deaths of inmates that occur in any local, regional, or community correctional facility conducted in the prior year pursuant to this section, including any trends or similarities identified by such reviews; (ii) any recommendations for policy changes to reduce the number of inmate deaths; and (iii) any recommendations for changes to the policies and procedures for conducting reviews of the deaths of inmates to improve the operations, safety, and security of local, regional, or community correctional facilities. On or before July 1, 2025, and each July 1 thereafter, The Board shall publish such report on its website and submit the report to the Governor, the Chairmen of the Senate Committee on Rehabilitation and Social Services, the House Committee on Public Safety, and the House Committee for Courts of Justice, the Speaker of the House of Delegates, and the President pro tempore of the Senate.

Code of Virginia §9.1-192.1. Civilian deaths in custody; annual report.

A. For the purposes of this section:

"Correctional facility" includes any local, regional, state, or juvenile correctional facility.

"Law enforcement agency" means any sheriff's office, police department, or other agency or department that employs persons who have law-enforcement authority that is under the direction and control of the Commonwealth or any local governing body.

B. Every law-enforcement agency and state or juvenile correctional facility shall report to the Department and every local or regional adult correctional facility shall report to the State Board of Local and Regional Jails the following information regarding the death of any person who is detained, under arrest or in the process of being arrested, en route to be incarcerated, or otherwise in the custody of such law-enforcement agency or correctional facility:

1. *The name, gender, race, ethnicity, and age of deceased;*
2. *The date, time, and location of death;*
3. *The law-enforcement agency or correctional facility that detained, arrested, or was in the process of arresting, transported, incarcerated, or otherwise had custody of the deceased; and*
4. *A brief description of the circumstances surrounding the death and the cause of death.*

C. Any law-enforcement agency or state or juvenile correctional facility that fails to comply with subsection B may, at the discretion of the Department, be declared ineligible for state grants or funds.

D. The Department and the State Board of Local and Regional Jails shall analyze the data submitted pursuant to subsection B to determine the means by which such information can be used to reduce the number of such deaths. The Director and the State Board of Local and Regional Jails shall report annually the findings and recommendations resulting from the analysis and interpretation of

the data to the Governor, the General Assembly, and the Attorney General beginning on or before July 1, 2025, and each July 1 thereafter.

E. Upon request, the State Board of Local and Regional Jails shall provide the data specified in subsection B to the Department to meet federal reporting requirements.

BOARD ROLES & RESPONSIBILITIES

The BLRJ is established in the Code of Virginia §53.1-2 and is comprised of eleven gubernatorial appointees and is authorized to:

- Establish operational and fiscal standards governing the operation of local and regional correctional facilities.
- Establish minimum standards for medical and behavioral health care services in local, regional, and community correctional facilities and procedures for enforcing such minimum standards.
- Develop and implement policies and procedures for the review of the death of any inmate that the Board determines warrants review that occurs in any local, regional, or community correctional facility.
- Establish minimum standards for the construction, equipment, administration, and operation of local correctional facilities and lockups.

DATA SOURCES

Sources for this report include:

- Facility Reports
- Investigative Reports
- Commonwealth of Virginia Compensation Board
- Virginia Department of Criminal Justice Services

REQUESTED RECORDS

Facilities are responsible for reporting inmate deaths to the BLRJ with accompanying relevant information. BLRJ jail death investigators utilize the following information:

- Intake and Inmate Records
- Medical/Behavioral Health Records
- Inmate Requests, Complaints, Grievances
- Inspection Notes
- Jail Reports, Records, Logs
- Video Footage
- Medical Examiner Reports
- Staff and Witness Written Statements
- Autopsy reports
- Inmate Recorded Phone Calls
- Third-party investigations, interviews, documents (local, federal) when applicable
- Triennial Audits and Annual Life, Health, Safety Inspections

JAIL DEATH REVIEW PROCESS

Pursuant to the Code of Virginia §53.1-69.1, the BLRJ shall have the power to review the death of any inmate who was incarcerated in a local correctional facility at the time of his death in order to determine whether the (i) circumstances surrounding the inmate's death, including identifying any act or omission by the facility or any employee or agent thereof that may have directly or indirectly contributed to the inmate's death, and (ii) whether the facility was in compliance with the regulations promulgated by the Board.

Review Process

1. Facilities are required to notify the BLRJ of the inmate death within 24 hours of the death. Notification is provided using the designated Report of Inmate Death form.
2. The jail death investigator requests a Report of Autopsy from the Office of the Chief Medical Examiner via the Department of Corrections' Office of Law Enforcement Services.
3. The jail death investigator reviews all relevant information regarding the death and reports to the Jail Review Committee (JRC).
4. Following review of relevant facts and circumstances surrounding each death, the JRC makes one of the following recommendations to the BLRJ:
    a. Close the review with a finding of no evidence that indicated the facility was out of compliance with the regulations promulgated by the BLRJ;
    b. Close the review with finding of evidence which indicates the facility was out of compliance with the regulations and the facility took corrective actions such that no further measures were necessary; or
    c. Recommend that the BLRJ proceed with adjudication under the Administrative Process Act, Code of Virginia §2.2-4018 et seq.
5. Upon completion, findings are reported to the Governor, the Speaker of the House of Delegates, and the President pro tempore of the Senate, in accordance with the Code of Virginia §53.1-69.1 (D).

DEATH REVIEW FINDINGS

The JRC met seven (7) times during calendar year 2024 (CY24) and reviewed thirty (30) deaths. Due to the level of detail, material volume, and time required to complete investigations, CY23 death reviews carried over into CY24.

CY24 Death Review Findings

Forty-eight (48) deaths were reported in CY24, a **6% decrease** from CY23.

- Five (5) deaths were not reviewed because the decedent was not in custody at the time of death.
- Sixteen (16) CY24 reviews were presented to the JRC in CY24.
    - Thirteen (13) reviews were closed without violations.
    - One (1) review resulted in a violation, an **89% decrease** from CY23.
        - The violation was for 6VAC15-40-1045 Supervision of Inmates. The review was closed due to corrective actions taken by the facility.
    - Two (2) reviews are in the appeals process.
        - One (1) review is in an appeals process for suspected violations of 6VAC15-40-5 Compliance Documentation and 6VAC15-40-1045 Supervision of Inmates.

- One (1) review is in an appeals process for a suspected violation of 6VAC15-40-1045 Supervision of Inmates.
- At the end of the reporting year for CY24 (December 31, 2024), twenty-seven (27) reviews remained open.

CY23 Death Review Findings

Fifty-one (51) deaths were reported in CY23, a **25% decrease** from CY22.

- One (1) death was not reviewed because the decedent was not in custody at the time of death.
- Thirty-five (35) CY23 reviews were presented to the JRC in CY23.
- Fourteen (14) CY23 reviews were presented to the JRC in CY24.
  - Forty (40) reviews were closed without violations.
  - Nine (9) reviews resulted in violations, a **47% decrease** from CY22. Eight (8) were found in violation of 6VAC15-40-1045 Supervision of Inmates, and one (1) was found in violation of 6VAC15-40-120 Classification and 6VAC15-40-1045 Supervision of Inmates.
  - Eight (8) reviews with violations were closed due to corrective actions taken by the facilities.
  - One (1) review resulted in a Compliance Plan
  - One (1) review is in an appeals process for a suspected violation of 6VAC15-40-1045 Supervision of Inmates.

CY22 Death Review Findings

Sixty-eight (68) deaths were reported in CY22, a **14% decrease** from CY21.

- Twelve (12) CY22 cases were presented to the JRC in CY22.
  - All reviews were closed without violations.
- Fifty-six (56) CY22 reviews were presented to the JRC in CY23.
  - Nineteen (19) of those reviews resulted in violations, a **5% increase** from CY21.
    - One (1) review violated 6VAC15-40-110 – Serious incident reports.
    - Three (3) reviews violated 6VAC15-40-360 – Twenty-four-hour emergency medical and mental health care.
    - One (1) review violated 6VAC15-40-400 – Management of pharmaceuticals.
    - Twelve (12) reviews violated 6VAC15-40-1045 – Supervision of inmates.
    - One (1) review violated 6VAC15-360 and 6VAC15-40-1045.
  - Five (5) of the nineteen (19) reviews are subject to a Compliance Plan. Two (2) reviews are in adjudication.

ACTIONS TAKEN BY FACILITIES

- Reviewed emergency medical policies for the facility and medical provider to enhance the continuity of care.
- Additional training for staff.
  - e.g., formal re-training of staff regarding supervision of inmates.
- Accountability of staff and administration.
  - e.g., deputies/officers/medical staff were terminated for violating policy and procedures.
- Highlighted the importance of following the facilities' policies and procedures during supervisory/officer meetings.
- Enhanced policy/procedure of supervision of inmates to ensure compliance with the BLRJ guidance for 6VAC15-40-1045 – Supervision of Inmates effective December 19, 2024.

- Added an automated system to track officer/deputy security rounds.
- Enhanced medical care.
    - e.g., additional medical staff.
- Changed health care contracted providers.
- Administrative and clinical mortality reviews.
- Continuous Quality Improvement Program in health care services.
- Incorporation of internal audits by supervisory and administrative staff to ensure compliance with regulations.

DEATHS BY FACILITY

The following table reflects the number of deaths reported by facilities for CY22, CY23, and CY24, with biennial totals.

- In CY22, there was a **14% decrease** in the number of reported inmate deaths from CY21.
- In CY23, there was a **25% decrease** in the number of reported inmate deaths from CY22.
- In CY24, there was a **6% decrease** in the number of reported inmate deaths from CY23.

Facility	CY22	CY23	CY24	Totals
Accomack County Jail	0	0	0	0
Albemarle-Charlottesville Regional Jail	1	2	0	3
Alleghany County Regional Jail	0	0	0	0
Arlington County Detention Center	1	2	0	3
Blue Ridge Regional Jail Authority (BRRJA) – Amherst	2	3	1	6
BRRJA – Bedford	0	0	0	0
BRRJA – Campbell	0	0	0	0
BRRJA – Halifax	1	1	1	3
BRRJA – Lynchburg	3	0	0	3
Botetourt-Craig Regional Jail	1	0	1	2
Bristol City	0	0	Closed	0
Central Virginia Regional Jail	0	0	0	0
Charlotte County Jail	1	0	0	1
Chesapeake Correctional Center	1	3	2	6
Chesterfield County Jail	0	0	2	2
Culpeper County Jail	0	1	0	1
Danville Adult Detention Center	1	1	0	2
Danville City Jail	1	0	1	2
Eastern Shore Regional Jail	0	0	0	0
Fairfax County Adult Detention Center	3	1	4	8
Fauquier County Adult Detention Center	1	0	0	1
Franklin County Jail	0	0	1	1
Gloucester County Jail	0	0	0	0

Facility	CY22	CY23	CY24	Totals
Halifax County Jail	0	0	0	0
Hampton City Jail	1	1	1	3
Hampton Roads Regional Jail	1	1	Closed	2
Henrico County Jail - East	0	0	1	1
Henrico County Jail - West	3	2	2	7
Henry County Adult Detention Center	2	1	0	3
Lancaster County Jail	0	0	0	0
Loudoun County Jail	0	0	1	1
Martinsville City Jail	0	0	0	0
Meherrin River Regional Jail	0	0	1	1
Middle Peninsula Regional Security Center	0	0	0	0
Middle River Regional Jail	0	1	1	2
Montgomery County Jail	1	0	0	1
New River Valley Regional Jail	2	0	0	2
Newport News City Jail	0	0	1	1
Norfolk City Jail	2	0	2	4
Northern Neck Regional Jail	0	0	1	1
Northwestern Regional Adult Detention Center	3	1	2	6
Page County Jail	0	0	0	0
Pamunkey Regional Jail	2	0	0	2
Patrick County Jail	0	0	0	0
Piedmont Regional Jail	0	0	1	1
Pittsylvania County Jail	0	0	1	1
Portsmouth City Jail	2	4	1	7
Prince William County-Manassas Adult Detention Center	1	0	1	2
Rappahannock Regional Jail	3	4	2	9
Rappahannock-Shenandoah-Warren (RSW) Regional Jail	2	0	0	2
Richmond City Justice Center	3	4	0	7
Riverside Regional Jail	4	2	6	12
Roanoke City Adult Detention Center	0	3	0	3
Roanoke County-Salem Jail	0	2	0	2
Rockbridge Regional Jail	0	0	0	0
Rockingham-Harrisonburg Regional Jail	0	1	0	1
Southampton County Jail	0	0	0	0
Southside Regional Jail	0	0	0	0
Southwest Virginia Regional Jail Authority (SWVRJA) – Abingdon	4	4	1	9
SWJRJA – Duffield	3	0	2	5
SWVRJA – Haysi	1	0	0	1
SWVRJA – Tazewell	1	0	2	3

Facility	CY22	CY23	CY24	Totals
Sussex County Jail	0	0	0	0
Virginia Beach Correctional Center	3	2	0	5
Virginia Peninsula Regional Jail	0	0	2	2
Western Tidewater Regional Jail	1	1	0	2
Western Virginia Regional Jail	5	2	2	9
William G. Truesdale Adult Detention Center (Alexandria)	1	1	1	3
Totals	**68**	**51**	**48**	**167**

No in custody deaths were reported at local lockups in CY22, CY23, and CY24; therefore, lockups are omitted from the above facility list.

Compared to the BLRJ's Annual Capacity Reports, the number of deaths reported by local and regional jails in CY22-CY24 consistently stayed below 1% of the Average Daily Population (ADP).

MANNER OF DEATH

The following table reflects the manner of death by calendar year.

MANNER	CY22	CY23	CY24
Natural	24	17	20
Suicide	20	18	8
Accident (Overdose)	17	13	4
Homicide	1	2	0
Pending	0	0	9
Undetermined	2	0	0
Unknown	4	1	7
TOTALS	68	51	48

**Pending is used for reviews awaiting the Report of Autopsy from the Office of the Chief Medical Examiner.*

***Undetermined is used by the Office of the Chief Medical Examiner when the circumstances of the death cannot point to a specific manner of death (e.g., intentional vs. unintentional overdose).*

***Unknown is used for deaths not reviewed by the BLRJ due to being released from custody before their death or for decedents who have died while on Home Electronic Monitoring and not investigated by the Office of the Chief Medical Examiner.*

Due to the large number of pending autopsy reports for CY24, a comparison was performed for CY22 and CY23.

Natural death was the leading manner of death in CY22, with a total of twenty-four (24). The leading method/cause of death for CY22 was pulmonary diseases or disorders, with a total of seven (7). The COVID-19 infection caused four (4) of the seven (7) pulmonary disease or disorder-related deaths. In CY23, there was a 29% decrease in natural deaths, totaling seventeen (17). Pulmonary disease or disorders also showed a reduction of 71% with only two (2) pulmonary disease or disorder-related deaths. Of the two (2), one was due to the COVID-19 infection. The leading cause of CY23 natural

deaths was due to cardiovascular diseases or disorders, with a total of eight (8). This was a 60% increase from CY22's five (5) cardiovascular disease or disorder-related deaths.

Suicide was the leading manner of death in CY23, with a total of eighteen (18). This was a 10% decrease from CY22. Seventeen (17) of the CY23 suicides were due to hanging, and one (1) was due to suffocation with rebreathing. Nineteen of the CY22 suicides were due to hanging, and one (1) was due to neck compression by ligature.

RECOMMENDATIONS

- Research the availability of technology to monitor the vital signs of inmates who are identified with health risks in real time and provide real time alerts.
- Enhance policy/procedure governing the observation of suicidal inmates. This includes provisions given to such inmates and the facility's ability to install cameras in the cells to monitor the inmates.
- Enhance policy/procedure for searching inmates upon entry into the facility.
- Additional training for inmate and cell searches.
- Analyze data by locality or region to identify patterns and areas requiring targeted interventions. For example, if suicide rates are higher in a specific region, immediate notification to the Community Services Board and the Department of Behavioral Health and Developmental Services would allow for appropriate mental health intervention.
- Collect detailed information on narcotics involved in overdoses. This could assist in identifying trends and potential intervention strategies, help tailor harm reduction strategies, and enhance medical protocols.

CONCLUSION

The BLRJ recognizes that any loss of life is a tragic event that profoundly impacts individuals, families, jail staff, jail inmates, and surrounding communities. Based on the report's findings, BLRJ's primary focus will be on the facilities' supervision of inmates and the inmates' medical and behavioral health needs.

From CY22 to CY24, the number of deaths reported in local and regional jails has continued to decline:

- **In CY22, 68 deaths were reported a 14% decrease from CY21.**
- **In CY23, the number dropped to 51, representing a 25% decrease from CY22.**
- **In CY24, 48 deaths were reported, a further 6% decrease from the previous year.**

According to the BLRJ's annual capacity reports, the number of deaths reported from CY22 to CY24 consistently remained below 1% of the average daily population in Virginia's local and regional jails.