ANNUAL REPORT OF JAIL DEATH REVIEWS CALENDAR YEAR 2025

Virginia State Board of Local and Regional Jails

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PURPOSE

The purpose of this report is to provide a comprehensive overview of deaths occurring in local and regional jails under the oversight of the State Board of Local and Regional Jail (the Board), as well as the outcomes of death reviews conducted during calendar year (CY) 2025. This report is prepared in accordance with the Code of Virginia (COV) § 53.1-69.1. Review of death of inmates in local, regional, or community correctional facilities[1], and § 9.1-192.1. Civilian deaths in custody; annual report[2], which grants the Board authority to review and report on jail serious incidents to include deaths.

By analyzing reported deaths, reviewing compliance with applicable standards, and documenting the Board's actions, the report supports the Board's statutory mandate to promote accountability, transparency, and continuous improvement in the care and supervision of individuals confined in local and regional jails.

JAIL REPORTING PROCESS

The review process begins when a jail notifies the Board of an inmate's death, as required by 6VAC15-40-110. Serious incident reports[3]. This regulation requires pertinent facts of deaths, discharges of firearms, erroneous releases, escapes, fires that require evacuation of inmates, hostage situations, and recaptures of escapees be initially reported to the Board within 24 hours, and a full report submitted at the end of investigation. These notifications should be submitted using the designated Serious Incident Report form.

For each reported death, the Board also collects the following demographic information, when available: decedent demographics (age, gender, race, and ethnicity), facility location, custody status at the time of death, circumstances surrounding the death, and applicable standards cited during any subsequent review.

BOARD REVIEW PROCESS

Pursuant to the COV §53.1-69.1, the Board 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.

[1] https://law.lis.virginia.gov/vacode/title53.1/chapter3/section53.1-69.1/
[2] https://law.lis.virginia.gov/vacode/title9.1/chapter1/section9.1-192.1/
[3] https://law.lis.virginia.gov/admincode/title6/agency15/chapter40/section110/

The Board designates two jail death investigators to perform Jail Death Reviews as agents of the Board. Upon receiving a report, the assigned jail death investigator requests a Report of Autopsy from the Office of the Chief Medical Examiner (OCME) through the Department of Corrections' Office of Law Enforcement Services, as well as a list of required documents from the facility.

The Board's jail death investigators utilize the following information to conduct Jail Death Reviews:

- Facility Reports
    - Intake and Inmate Records
    - Medical/Behavioral Health Records
    - Inmate Requests, Complaints, Grievances
    - Jail Reports, Records, Logs
    - Video Footage
    - Staff and Witness Written Statements
    - Inmate Recorded Phone Calls
- Third-party investigations, interviews, documents (local, federal) when applicable
- Triennial Audits and Annual Life, Health, Safety Inspections
- Virginia Compensation Board Average Daily Population Reports
- Virginia Department of Criminal Justice Services Death Reporting and Recommendations

After obtaining the necessary documents, the jail death investigator reviews all relevant information about the death and reports the findings, including the facts and circumstances, to the Jail Review Committee (JRC).

The JRC makes one of the following recommendations to the Board:

- Close the review with a finding of no evidence indicating the facility was out of compliance with the regulations promulgated by the Board;
- Close the review with a finding of evidence that indicates the facility was out of compliance with the regulations and that the facility took corrective actions such that no further measures were necessary; or
- Recommend that the Board proceed with adjudication

Upon Board action, a report is submitted to the Governor, the Speaker of the House of Delegates, and the President pro tempore of the Senate in accordance with COV §53.1-69.1(D).

JAIL REPORTED DEATH TOTALS BY CY

This section provides an overview of local and regional jail deaths reported during CY2023-CY2025. Data is presented to reflect the total number of deaths, including those occurring in custody and those occurring after release, based on information submitted to the Board pursuant to COV reporting requirements.

The table below summarizes reported deaths by CY, providing a baseline for understanding overall trends and the scope of deaths reviewed. These data serve as the foundation for subsequent analysis, including facility-level breakdowns, demographic characteristics, and findings from death review presentations.

Table 1: Reported Deaths by Custody Status, CY2023-CY2025

	CY2023	CY2024	CY2025
Total Deaths Reported	51	48	58
Released From Custody	1 (2.0%)	5 (10.4%)	4 (4.9%)
Within Authority	50 (98%)	43 (89.6%)	54 (93.1%)

Percentages reflect the proportion of total reported deaths for each CY. "Released From Custody" indicates a change in legal custody status after transfer from the jail to an outside medical facility during a serious medical event. Deaths occurring after release from custody fall outside the Board's statutory review authority; however, these incidents have been reported to the Board pursuant to 6VAC15-40-110. "Within Authority" includes deaths occurring while the individual was in custody and subject to Board review pursuant to COV §53.1-69.1.

In CY2025, the Board received 58 reported deaths, representing:

- 20.8% increase from CY2024 (48 deaths)
- 13.7% increase from CY2023 (51 deaths)

Of the total deaths reported:

- 93% of CY2025 deaths occurred while in custody and were subject to Board review.
- This is compared to 89.6% in CY2024 and 98% in CY2023.

Although annual totals fluctuate, the Board's review authority remains limited to deaths that happen while a person is in custody at a local or regional jail. If an injury or illness occurs during custody but the person dies after being released from custody, on compassionate release or furlough, or transferred to a state-run hospital, then the death is not within the Board's statutory review scope.

JAIL REPORTED DEATHS BY FACILITY

This section presents local and regional jail reported deaths by facility. Data are provided for the three-year period (CY2023-CY2025) to show overall trends, with a more detailed analysis of CY2025 to reflect current conditions.

Deaths are categorized as in custody or released, based on whether the individual remained in the custody of the jail at the time of death. Jails with zero reported deaths during the reporting period are included for completeness.

Table 2: Deaths by Facility and Custody Status (CY2023-CY2025)

	CY2023		CY2024		CY2025		
Facility	**In Custody**	**Released**	**In Custody**	**Released**	**In Custody**	**Released**	**Total**
Accomack County Jail	0	0	0	0	0	0	**0**
Albemarle-Charlottesville Regional Jail	2	0	0	0	0	0	**2**
Alleghany Regional Jail	0	0	0	0	1	0	**1**
Arlington County Detention Facility	2	0	0	0	0	0	**2**
Blue Ridge Regional Jail Authority - Amherst	2	1	1	0	2	0	**6**
Blue Ridge Regional Jail Authority - Bedford	0	0	0	0	0	0	**0**
Blue Ridge Regional Jail Authority - Campbell	0	0	0	0	0	0	**0**
Blue Ridge Regional Jail Authority - Halifax	1	0	1	0	0	0	**2**
Blue Ridge Regional Jail Authority - Lynchburg	0	0	0	0	2	0	**2**
Botetourt County Jail	0	0	1	0	2	0	**3**
Central Virginia Regional Jail	0	0	0	0	2	0	**2**
Charlotte County Jail	0	0	0	0	0	0	**0**
Chesapeake Correctional Center	3	0	2	0	0	0	**5**
Chesterfield County Jail	0	0	2	0	0	0	**2**
Culpeper County Jail	1	0	0	0	0	0	**1**
Danville Adult Detention Center	1	0	0	0	0	0	**1**
Danville City Jail	0	0	0	1	1	0	**2**
Eastern Shore Regional Jail	0	0	0	0	0	0	**0**
Fairfax County Adult Detention Center	1	0	4	0	2	0	**7**
Fauquier County Adult Detention Center	0	0	0	0	0	0	**0**
Franklin County Jail	0	0	1	0	0	0	**1**
Gloucester County Jail	0	0	0	0	0	0	**0**
Hampton City Correctional Center	1	0	1	0	0	0	**2**
Hampton Roads Regional Jail[4]	1	0	0	0	0	0	**1**
Henrico County Jail - East	0	0	1	0	1	0	**2**
Henrico County Jail - West	2	0	2	0	2	0	**6**
Henry County Adult Detention Center	1	0	0	0	0	0	**1**
Lancaster County Adult Detention Center	0	0	0	0	0	0	**0**
Loudon County Adult Detention Center	0	0	1	0	1	0	**2**
Martinsville City Jail	0	0	0	0	1	0	**1**
Meherrin River Regional Jail	0	0	1	0	0	0	**1**

[4] The Hampton Roads Regional Jail closed in CY2024

Middle Peninsula Regional Security Center	0	0	0	0	0	0	**0**
Middle River Regional Jail	1	0	1	0	0	0	**2**
Montgomery County Jail	0	0	0	0	0	0	**0**
New River Valley Regional Jail	0	0	0	0	1	0	**1**
Newport News City Jail	0	0	1	0	3	0	**4**
Norfolk City Jail	0	0	2	0	2	0	**4**
Northern Neck Regional Jail	0	0	1	0	0	0	**1**
Northwestern Regional Adult Detention Center	1	0	2	0	1	0	**4**
Page County Jail	0	0	0	0	1	0	**1**
Pamunkey Regional Jail	0	0	0	0	2	0	**2**
Patrick County Jail	0	0	0	0	0	0	**0**
Piedmont Regional Jail	0	0	1	0	2	0	**3**
Pittsylvania County Jail	0	0	1	0	1	0	**2**
Portsmouth City Jail	4	0	1	0	0	0	**5**
Prince William - Manassas Regional Jail	0	0	1	0	1	0	**2**
Rappahannock Regional Jail	4	0	2	0	1	0	**7**
Richmond City Justice Center	4	0	0	0	4	0	**8**
Riverside Regional Jail	2	0	5	1	4	0	**12**
Roanoke City Adult Detention Center	3	0	0	0	2	2	**7**
Roanoke County Jail	2	0	0	0	0	0	**2**
Rockbridge Regional Jail	0	0	0	0	0	0	**0**
Rockingham-Harrisonburg Regional Jail	1	0	0	0	0	0	**1**
RSW Regional Jail	0	0	0	0	1	0	**1**
Southampton County Jail	0	0	0	0	0	0	**0**
Southside Regional Jail	0	0	0	0	0	0	**0**
Southwest Virginia Regional Jail Authority - Abingdon	4	0	1	0	3	0	**8**
Southwest Virginia Regional Jail Authority - Duffield	0	0	2	0	1	0	**3**
Southwest Virginia Regional Jail Authority - Haysi	0	0	0	0	3	0	**3**
Southwest Virginia Regional Jail Authority - Tazewell	0	0	2	0	0	1	**3**
Sussex County Jail	0	0	0	0	0	0	**0**
Virginia Beach Correctional Center	2	0	0	0	2	0	**4**
Virginia Peninsula Regional Jail	0	0	0	2	0	0	**2**
Western Tidewater Regional Jail	1	0	0	0	0	0	**1**
Western Virginia Regional Jail	2	0	1	1	2	0	**6**
William G. Truesdale Adult Detention Center (City of Alexandria)	1	0	1	0	0	1	**3**
Total	**51**		**48**		**58**		**157**

- In CY2025, 58 deaths were reported by local and regional jails
- In CY2024, 48 deaths were reported by local and regional jails
- In CY2023, 51 deaths were reported by local and regional jails

Most deaths occurred in custody, with a smaller number occurring after release. Deaths were distributed across facilities of varying sizes and types, with some facilities reporting multiple deaths over the three-year period and others (10 total) reporting none.

This variation reflects differences in facility size, population, and operational characteristics and underscores the importance of considering both total counts and relative measures, such as rates, when evaluating facility-level data.

Table 3: Deaths by Facility, Custody Status, and Rate per 1,000 Average Daily Population (ADP), CY2025

Facility	In Custody	Released	Total	ADP	Rate per 1,000
Alleghany Regional Jail	1	0	1	84.0	11.9
Blue Ridge Regional Jail Authority - Amherst	2	0	2	395.0	5.1
Blue Ridge Regional Jail Authority - Lynchburg	2	0	2	422.8	4.7
Botetourt County Jail	2	0	2	100.7	19.9
Central Virginia Regional Jail	2	0	2	433.0	4.6
Danville City Jail	1	0	1	198.7	5.0
Fairfax County Adult Detention Center	2	0	2	538.6	3.7
Henrico County Jail - East & West	3	0	3	1060.79	2.8
Loudon County Adult Detention Center	1	0	1	274.2	3.6
Martinsville City Jail	1	0	1	108.0	9.3
New River Valley Regional Jail	1	0	1	602.4	1.7
Newport News City Jail	3	0	3	478.0	6.3
Norfolk City Jail	2	0	2	759.1	2.6
Northwestern Regional Adult Detention Center	1	0	1	619.6	1.6
Page County Jail	1	0	1	71.7	13.9
Pamunkey Regional Jail	2	0	2	392.3	5.1
Piedmont Regional Jail	2	0	2	464.6	4.3
Pittsylvania County Jail	1	0	1	85.6	11.7
Prince William - Manassas Regional Jail	1	0	1	524.9	1.9
Rappahannock Regional Jail	1	0	1	1202.2	0.8
Richmond City Justice Center	4	0	4	600.5	6.7
Riverside Regional Jail	4	0	4	1108.7	3.6
Roanoke City Adult Detention Center	2	2	4	354.2	11.3
RSW Regional Jail	1	0	1	294.3	3.4
Southwest Virginia Regional Jail Authority - Abingdon	3	0	3	756.4	4.0
Southwest Virginia Regional Jail Authority - Duffield	1	0	1	446.0	2.2
Southwest Virginia Regional Jail Authority - Haysi	3	0	3	295.3	10.2
Southwest Virginia Regional Jail Authority - Tazewell	0	1	1	133.9	7.5

Virginia Beach Correctional Center	2	0	2	1043.9	1.9
Western Virginia Regional Jail	2	0	2	624.9	3.2
William G. Truesdale Adult Detention Center (City of Alexandria)	0	1	1	256.1	3.9

* The Virginia State Compensation Board considers Henrico County Jail East and West as a single entity. These figures were combined here to represent the known ADP.

In CY2025, deaths were reported across multiple local and regional jails, with variation in both total counts and calculated rates. When viewed alongside ADP, these data provide important context for understanding facility-level differences.

Most facilities reported one or two deaths, while a smaller number reported higher totals. When standardized by population, death rates varied more widely, reflecting differences in facility size. Facilities with smaller ADP values may exhibit higher rates even when the number of deaths is low, while larger facilities may report more deaths overall but at lower rates relative to their population.

Overall, the distribution of reported deaths across facilities does not follow a single pattern but instead reflects the influence of population size, facility type, and case mix. For this reason, both the total number of reported deaths and the rates per 1,000 ADP should be considered together when interpreting facility-level data. These data support the Board's continued focus on system-wide trends and on targeting quality improvement efforts, rather than on comparisons between individual facilities.

DECEDENT DEMOGRAPHICS

Demographic data collection has grown over time. While gender has always been reported, data on race, ethnicity, and age started in October 2024 following legislative changes pursuant to COV §9.1-192.1. As a result, demographic information from earlier years is limited and not fully comparable across the three-year analysis.

Table 4: Decedent Gender by Year (CY2023-CY2025)

Year	Male	Female	Total	% Male	% Female
CY2023	43	8	51	84.3%	15.7%
CY2024	36	12	48	75.0%	25.0%
CY2025	53	5	58	91.4%	8.6%
Total	**132**	**25**	**157**	**84.1%**	**15.9%**

Gender data showed that males accounted for most decedents each year, at 84.3% in CY2023, 75% in CY2024, and 91.4% in CY2025. Overall, males accounted for 84.1% of decedents over the three-year span.

Table 5: Decedent Demographics, CY2025

Characteristic	Category	Number of Decedents	Percent of Total (n=58)
Gender	Male	53	91.4%
	Female	5	8.6%
Race	Asian	1	2%
	Black/African American	23	40%
	White	34	59%
Ethnicity	Hispanic/Latino	0	0%
	Not Hispanic/Latino	58	100%
Age Group	18-35	16	27.6%
	36-64	38	65.5%
	65+	4	6.9%

Percentages may not total exactly 100% due to rounding.

Out of the 58 deaths reported to the Board in CY2025, most of the decedents were male (91.4%) and White (59%), followed by Black/African American (40%) and Asian (2%). No decedents were reported as Hispanic or Latino. The largest age group was 36-64 years (65.5%), followed by 18-35 years (27.6%), and 65 years old and older (6.9%).

JAIL DEATH REVIEWS

This section summarizes Jail Death Reviews conducted by the JRC and formally presented to the Board. Presentations provide a structured forum for the Board to examine the circumstances of each death, assess compliance with applicable standards and regulations, and monitor trends over time.
Due to case complexity, investigation timelines, and administrative processes, reviews may occur in a CY different from the year of the death. As a result, the Board routinely reviews deaths from both the current and prior CYs.

- In CY2025, the JRC met six times and reviewed 43 deaths
- In CY2024, the JRC met seven times and reviewed 30 deaths
- In CY2023, the JRC met 15 times and reviewed 129 deaths

The number of meetings and reviews reflects the Board's continued commitment to thorough and timely Jail Death Reviews.

BOARD ACTIONS

This section shows the results of the Board based on cases closed by CY. Board actions indicate violations of the Virginia Administrative Code - Title 6. Criminal Justice And Corrections - Agency 15. State Board of Local and Regional Jails - Chapter 40. Minimum Standards for Jails and Lockups[5] were found. Board violations may involve one or multiple standards, and the Board may initiate adjudication when necessary.

Data is organized by the total number of case closures, the number of cases the Board closed with violations, and the specific standards cited. Presenting data in this format allows the Board to assess compliance trends, identify recurring areas of concern, and maintain consistent oversight of local and regional jails.

Table 6: Board Case Closures (CY2023-CY2025)

CY2025	CY2024	CY2023
47	37	118

Case closures refer to when the Board finalized its review and issued a final decision, regardless of when the case was initially submitted.

Table 7: Cases Closed With vs. Without Violation

Category	CY2025	CY2024	CY2023
Violation	14 (29.8%)	4 (10.8%)	24 (20.3%)
No Violation	33 (70.2%)	33 (89.2%)	94 (79.7%)

Table 8: Cases Closed With Single vs. Multiple Violations

Category	CY2025	CY2024	CY2023
Single Violation	10 (71.4%)	4 (100%)	23 (95.8%)
Multiple Violations	4 (28.6 %)	0 (0%)	1 (4.2%)

Overall, this demonstrates that while most violations involve a single violation, a small but significant number of reviews involve multiple standards, highlighting complex or recurring violations.

[5] https://law.lis.virginia.gov/admincode/title6/agency15/chapter40/

Table 9: Violations by Specific Standard

Standard	CY2025	CY2024	CY2023
6VAC15-40-5. Compliance documentation.[6]	1	0	0
6VAC15-40-110. Serious incident reports.[7]	0	0	1
6VAC15-40-120. Classification.[8]	0	0	1
6VAC15-40-360. Twenty-four-hour emergency medical and mental health care.[9]	4	0	9
6VAC15-40-370. Receiving and medical screening of inmates.[10]	1	0	0
6VAC15-40-400. Management of pharmaceuticals.[11]	0	0	2
6VAC15-40-420. Transfer of summaries of medical record.[12]	1	0	0
6VAC15-40-440. Medical care provided by personnel other than physician.[13]	1	0	0
6VAC15-40-1045. Supervision of inmates.[14]	11	4	12

Total counts here represent the number of times each standard was cited; a single review may cite multiple standards.

The table shows the Board which standards are most often involved in closure cases. It emphasizes that while a few standards make up most citations, others are cited only occasionally.

FACILITY ACTIONS

This section summarizes the corrective actions taken by local and regional jails after the Board's findings of violations of the Minimum Standards for Jails and Lockups or upon the completion of the facility's internal review. Some facilities recognized violations and implemented corrective measures before the review was presented to the JRC. Overall, these actions aim to address identified deficiencies, enhance compliance, improve inmate safety, and prevent similar incidents in the future.

Corrective Actions Implemented

Personnel Actions

- Written reprimands
- Suspensions without pay
- Performance improvement plans

[6] https://law.lis.virginia.gov/admincode/title6/agency15/chapter40/section5/
[7] https://law.lis.virginia.gov/admincode/title6/agency15/chapter40/section110/
[8] https://law.lis.virginia.gov/admincode/title6/agency15/chapter40/section120/
[9] https://law.lis.virginia.gov/admincode/title6/agency15/chapter40/section360/
[10] https://law.lis.virginia.gov/admincode/title6/agency15/chapter40/section370/
[11] https://law.lis.virginia.gov/admincode/title6/agency15/chapter40/section400/
[12] https://law.lis.virginia.gov/admincode/title6/agency15/chapter40/section420/
[13] https://law.lis.virginia.gov/admincode/title6/agency15/chapter40/section440/
[14] https://law.lis.virginia.gov/admincode/title6/agency15/chapter40/section1045/

- Termination of multiple officers or deputies for failures in inmate supervision
- Termination of a nurse following violations of medical care and intake practices
- Written reprimands and unpaid suspensions for staff involved in supervisory failures

Policy and Procedure Revisions

- Supervision and security check procedures
- Medical screening protocols
- Withdrawal monitoring procedures
- Medical clearance requirements for new committals
- Communication procedures between medical and security staff

Staff Training and Education

- Retraining nursing staff on intake and assessment requirements
- Education regarding withdrawal monitoring and escalation of care
- Refresher training on inmate supervision requirements
- Training in recognition of medical emergencies

Enhanced Medical Oversight

- Annual review of medical protocols
- Creation of Continuous Quality Improvement (CQI) chart review programs
- Additional medical staffing positions
- Expanded healthcare provider involvement in clinical decision-making
- Improved communication processes between medical and security personnel

Technology and Monitoring Improvements

- Automated security rounds systems
- Internal auditing programs
- Enhanced documentation review procedures
- Nursing round logs in intake areas

Compliance Plan

In CY2025, one facility was released from a compliance plan related to violations of 6VAC-40-1045 (Supervision of Inmates) found in the review of deaths occurring in CY2021 and CY2022.

Actions completed under the plan included:

- Implementation of an automated security rounds system
- Internal compliance audits
- Officer terminations and reprimands
- Officer retraining
- Revision of supervision policies and procedures

MANNER OF DEATH

The following section provides a triennial comparison of reported deaths by manner (CY2023-CY2025). "Manner of death" refers to the OCME's classification of how a death occurred (e.g., natural, suicide, accident, homicide, undetermined).

The OCME defines each manner of death as follows:

- "Accident – The manner of death used when there is no evidence of intent; an unintentional, sudden, and unexpected death.
- Homicide – The manner of death in which death results from the intentional harm of one person by another.
- Natural – The manner of death used when a disease alone causes death. If death is hastened by an injury, the manner of death is not considered natural.
- Suicide – The manner of death in which death results from the purposeful attempt to end one's life.
- Undetermined – The manner of death for deaths in which there is insufficient information to assign another manner. An undetermined death may have an undetermined cause of death and an unknown manner, an undetermined cause of death and a known manner, or a determined cause of death and an unknown manner."[15]

The Board uses "pending" to identify deaths awaiting the OCME's determination of the cause and manner of death. Additionally, the Board uses "unknown" to include individuals who were released from custody or on home electronic monitoring at the time of death.

Tracking the manner of death over time helps the Board identify trends, monitor prevention efforts, and maintain transparency in reporting.

[15] https://www.vdh.virginia.gov/content/uploads/sites/18/Annual-Report-2023.pdf

Graph 1: Manner of Death by Calendar Year

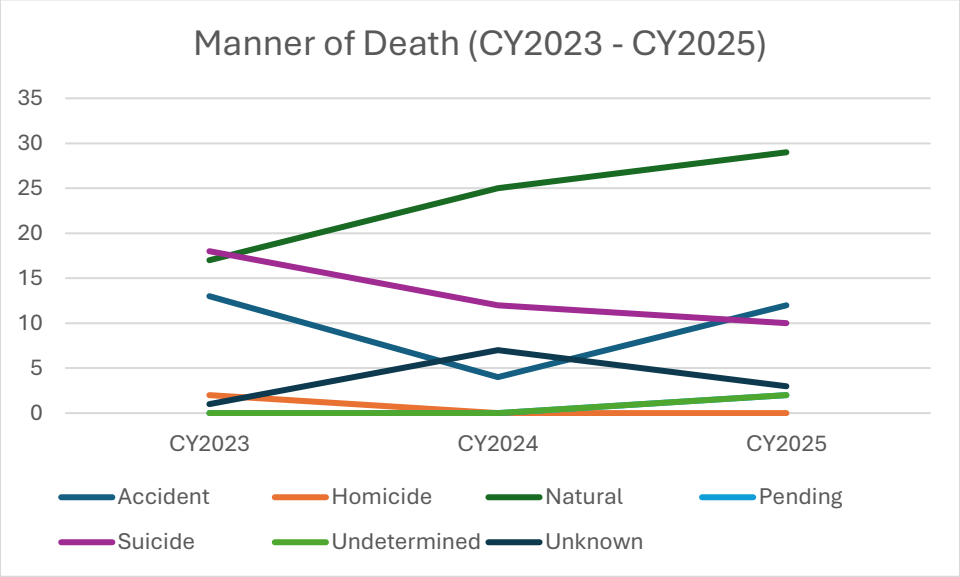

Table 10: Manner of Death (MOD)

MOD	CY2023	CY2024	CY2025	TOTALS
Accident	13	4	12	**29**
Homicide	2	0	0	**2**
Natural	17	25	29	**71**
Pending	0	0	2	**2**
Suicide	18	12	10	**40**
Undetermined	0	0	2	**2**
Unknown	1	7	3	**11**

Over the three-year period (CY2023-2025), natural causes have become the predominant manner of death, increasing from 17 (33.3%) of total deaths in CY2023 to approximately 50% in both CY2024 and CY25.

Deaths by suicide declined steadily during this period, decreasing from 18 (35.3%) of total deaths in CY2023 to 10 (17.2%) in CY2025.

Accidental deaths fluctuated year-to-year, declining in CY2024 and increasing again in CY2025.

No homicides were reported in CY2024 or CY2025.

In CY2025, there were two deaths for which the manner of death was classified as undetermined by the OCME, whereas no such cases were reported in the preceding two years.

A small number of deaths remain pending final determination for CY2025.

This section summarizes the primary causes of reported deaths in CY2025. “Cause of death” refers to the medical condition or event that directly led to the death, as determined by the OCME.

For clarity, causes have been grouped into high-level categories. Pending or unknown deaths are included to ensure all reported deaths are represented.

Table 11: CY2025 Cause of Death (Counts and Percentages)

Category	Count	Percent of Total Deaths
Cardiovascular Disease	17	29.3%
Cancer	3	5.2%
Infectious Disease	5	8.6%
Other Chronic Medical Conditions	5	8.6%
Hanging	10	17.2%
Drug Toxicity	9	15.5%
Blunt Force Trauma	4	6.9%
Pending/Unknown	5	8.6%
Total Deaths	**58**	**100%**

In CY2025, natural deaths were most frequently linked to cardiovascular disease (29%), followed by other chronic medical conditions (9%), infectious disease (9%), and cancer (5%). Suicide deaths accounted for 17% of total deaths, all by hanging. Accidental deaths include drug toxicity (7%) and blunt force trauma (7%). Five deaths (9%) remain pending cause determination or are classified as unknown, including individuals who were released from custody or were on home electronic monitoring at the time of death. These categories reflect the primary causes determined by the OCME.

RECOMMENDATIONS

The following recommendations are organized by the key areas identified in the Board's review process. Each recommendation includes supporting context and suggested actions. Topics include:

- Legislative Clarification of Inmate Deaths
- Most Frequently Cited Regulations
- Health Care Services
- Substance Use Disorders
- Suicide Prevention and Ligature Risk Reduction

The Board recognizes that implementing certain recommendations may have fiscal or operational impacts and may not be feasible for all localities. Facilities are encouraged to consider these recommendations and assess available resources and operational needs.

Legislative Clarification of Inmate Deaths

Under current practice, deaths that occur after an individual's legal custody status has changed, such as following release on bond, court order, or furlough during hospitalization, fall outside the

Board's review authority under COV §§ 53.1-5 (5) and 53.1-69.1 even when the underlying medical emergency originated while the individual was confined in a local or regional jail and required transfer to an outside medical facility for treatment. This distinction may limit the Board's ability to fully evaluate deaths where custodial care, clinical response, and transfer decision-making may be directly relevant to the outcome.

The Board suggests clarifying and potentially broadening its review authority to include deaths of individuals who experience a serious medical event while in custody and are subsequently transferred to a medical facility-for treatment, even if their legal custody status changes prior to death due to bond, court orders, or furlough. This clarification would support more comprehensive oversight, ensure a consistent review of jail-originated medical emergencies, and strengthen the Board's ability to identify systemic trends and improve practices related to inmate health and safety.

Most Frequently Cited Regulations

6VAC15-40-1045 - Supervision of inmates

Given the repeated citations (27) over a three-year period, the Board recommends that facilities prioritize ongoing quality improvement in inmate supervision practices.

Facilities should ensure compliance with twice-per-hour, irregular checks and accurate documentation; incorporate routine supervisory audits; provide targeted refresher training to reinforce expectations for observation and documentation; and assess housing areas to maintain unobstructed visibility of inmates.

Sustained attention to these measures and the Board's Guidance Documents for Supervision of Inmates[16] are necessary to address recurring deficiencies and to support safe and effective supervision of inmates.

6VAC15-40-360 - Twenty-four-hour emergency medical and mental health care.

The second most-cited standard (13) over a three-year period, often in cases where symptoms were not recognized, or escalation of care did not occur. The Board recommends focusing quality improvement efforts on early identification and response to medical and mental health needs.

Facilities should reinforce staff training on recognizing emergency medical and mental health symptoms, including when to escalate care. They should also ensure clear protocols are in place for timely referrals to medical or mental health providers and emergency services. Additionally, conducting supervisory and clinical audits of response times and escalation practices helps identify gaps and improve compliance.

Focusing on early symptoms and timely intervention will support compliance and improve the delivery of emergency care.

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16 https://www.townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\GuidanceDocs\701\GDoc_DOC_7857_v2.pdf

While many deaths result from natural disease processes, these deaths emphasize opportunities to improve early detection, prompt escalation of care, and management of complex medical conditions within the jail setting.

Recognition and Escalation of Acute Medical Conditions

Given multiple deaths related to sepsis, embolic events, organ failure, and cardiac complications, the Board recommends improving early recognition and escalation protocols for serious medical conditions.

Facilities should implement standardized early warning tools (e.g., sepsis screening, vital sign triggers) to identify deterioration; require timely escalation protocols for abnormal findings, including defined thresholds for providers' notification and Emergency Medical Services (EMS) activation; conduct focused training on high-risk presentations (e.g., infection, chest pain, shortness of breath, abdominal pain, altered mental status); and incorporate case-based CQI reviews of deaths involving delayed recognition or response.

Management of Chronic and High-Risk Conditions

Several deaths involved endocarditis, cardiomyopathy, diabetes, kidney disease, and infectious complications, often linked to substance use disorders.

Facilities should identify and flag individuals with high-risk chronic conditions at intake and during incarceration; ensure continuous care through prompt medical evaluation, medication management, and referral to specialists when needed; improve monitoring for those with known heart, infectious, or metabolic conditions; and strengthen coordination between security and medical staff for symptom reporting and follow-up.

Infection Control and Sepsis Prevention

Many cases involved sepsis or other serious infections, including soft-tissue infections and systemic complications.

Facilities should strengthen protocols for early detection and treatment of infection, including wound care and monitoring for deterioration; ensure prompt access to diagnostic testing and antibiotics when necessary; train staff on the signs of sepsis and rapid-response protocols; and review cases involving infection-related deaths through CQI processes to identify missed opportunities for intervention.

Substance Use and Associated Medical Risk

Several cases show complications associated with chronic substance use, including endocarditis and multi-system disease.

Facilities should improve screening for substance use disorders and related medical issues during intake; ensure access to proper withdrawal management and ongoing treatment services; train

staff on medical risks linked to substance use, such as infection and heart problems; and monitor individuals with known substance use histories for new medical concerns.

Documentation and Communication

Across these cases, outcomes can be affected by how effectively symptoms are documented, communicated, and addressed.

Facilities should ensure clear and timely documentation of symptoms, assessments, and actions taken; improve handoff communication between shifts and between security and medical staff; and include documentation review in routine supervisory and CQI audits.

Substance Use Disorders

The high proportion of drug toxicity-related deaths underscores the ongoing challenges associated with substance use and highlights the need for comprehensive prevention, detection, and response strategies within local and regional jails.

Overdose Prevention and Response

Since most accidental deaths resulted from drug toxicity, the Board recommends enhancing overdose prevention and rapid response efforts.

Facilities should ensure easy access to naloxone (Narcan) in all housing units and require staff to be trained in its use; reinforce protocols for immediate medical response when overdose is suspected; conduct regular drills and refresher training on recognizing and responding to overdoses; and include overdose incidents in CQI reviews to identify response gaps.

Intake Screening and Ongoing Monitoring

Substances identified (e.g., fentanyl, cocaine, methamphetamine) show both opioid and stimulant risks, often occurring together.

Facilities should improve intake screening to detect recent substance use, overdose history, and polysubstance risks; implement increased observation protocols for individuals at overdose risk, especially during the initial confinement period; and provide timely medical and mental health follow-up for those identified as high risk.

Contraband Control and Detection

The presence of illegal substances indicates ongoing drug entry into facilities.

Facilities should enhance contraband interdiction strategies, including conducting searches, screening mail, and monitoring common entry points; assess current practices and explore improved detection methods where feasible; and train staff on emerging drug threats, such as synthetic opioids and adulterants (e.g., xylazine).

Substance Use Treatment and Harm Reduction

Patterns of polysubstance use emphasize the importance of continuous treatment and risk reduction.

Facilities should expand access to substance use disorder treatment, including medication-assisted treatment (MAT) where appropriate; provide education to inmates on overdose risks, particularly related to fentanyl and mixed substances; and coordinate with community providers to support continuity of care upon release.

Data Monitoring and Trend Analysis

Given the concentration of overdose-related deaths, ongoing monitoring is critical.

Facilities should monitor and analyze overdose incidents and near-misses to identify trends; integrate findings into CQI processes to inform targeted interventions; and share relevant data with stakeholders to support system-wide prevention efforts.

Suicide Prevention and Ligature Risk Reduction

Since most suicide deaths involve hanging, the Board recommends focused prevention efforts on environmental safety, active supervision, and prompt intervention.

Facilities should conduct regular assessments of housing units to identify and mitigate ligature points, especially in intake, medical, and administrative segregation areas. Ensure individuals identified as at risk are placed in suicide-resistant environments, including the use of appropriate safety cells and protective clothing when needed. Reinforce policies requiring frequent, irregular interval checks with direct visualization and ensure these checks are accurately documented. Provide comprehensive mental health screenings at intake, including assessments of suicide risk and prior history. Offer timely access to mental health evaluations and follow-up care. Maintain ongoing monitoring of individuals identified as at risk. Strengthen communication between security and mental health staff regarding behavioral changes or reported concerns. Train staff in immediate response procedures, including the use of emergency equipment and timely intervention.

CONCLUSION

This report offers a thorough review of deaths in local and regional jails, along with the Board's oversight through Jail Death Review presentations, review closures, and subsequent actions. The data illustrate both the volume and complexity of the deaths reviewed.

Analysis of the data highlights several key areas for ongoing improvement, such as inmate supervision, prompt identification and escalation of medical and mental health issues, suicide prevention, and risks related to substance use. Although many deaths are caused by natural factors, the findings reveal opportunities to strengthen practices, improve communication, and boost response efforts across facilities.

The Board’s review process, aided by collaboration with facilities, provides essential insights into system performance and areas for improvement. Through targeted recommendations and ongoing monitoring, the Board aims to foster safer environments, enhance outcomes, and ensure consistent compliance with established standards.

Finally, clarifying the Board's statutory authority to review deaths of individuals who were released from custody after an injury or illness that began while in a local or regional jail would further strengthen its ability to conduct thorough reviews and ensure that all relevant deaths are assessed.