Commonwealth of the Northern Mariana Islands
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Commonwealth of the Northern Mariana Islands
FY 2023
Justice Assistance Grant Application
Death in Custody Reporting Act (DCRA) Implementation Plan

US Department of Justice, Office of Justice Programs,
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The Death in Custody Reporting Act (DCRA) (Public Law 113-242) requires all states to report to the Attorney General information regarding the death of any person who is detained, under arrest, in the process of being arrested, enroute to be incarcerated or detained; or incarcerated at a municipal or county jail, state prison, state-run boot camp prison, boot camp prison that is contracted out by the state, any state or local contract facility, or other local or state correctional facility (including any juvenile facility). Data on deaths in custody are crucial for holding law enforcement and correctional facilities across the country accountable. The enactment of the DCRA was to allow for accurate and complete information on the number of people who die in custody and the nature of such deaths to allow policymakers to examine the underlying causes and provide recommendations to lower the incidence.

As part of the Edward Byrne Memorial Justice Assistance Grant (JAG) reporting requirement, State Administering Agencies (SAAs) are responsible for collecting DCRA data quarterly from state and local entities and submitting that data to the Bureau of Justice Assistance (BJA) Performance Measurement Tool. Beginning with the Fiscal Year 2019 Byrne JAG solicitation, CJPA has been reporting the DCRA data to ensure compliance with PL 113-242. Since 2019, the Bureau of Statistics and Plans (Bureau), designated SAA for the Edward Byrne JAG Program, has collaborated with the Department of Public Safety and the Department of Correction. These entities are the recognized law enforcement agencies of individuals detained due to arrest or incarceration.

To meet the FY 2023 Edward Byrne Memorial Justice Assistance Grant (JAG) Program State Solicitation requirement to submit a plan for DCRA data collection and reporting in accordance with Public Law 113-242, the following is the draft of the CNMI's DCRA State Implementation Plan demonstrating CNMI's understanding of DCRA reporting requirements and the process utilized in gathering the required data as a recipient of federal funds under the Byrne JAG Program. CNMI's DCRA State Implementation Plan will outline the data collection infrastructure, the data collection method, and the data reporting method that is used to meet the reporting requirements of the DCRA.

The Commonwealth of the Northern Mariana Islands (CNMI) currently does not have a law that requires local agencies to report any data related to deaths that occur while in custody. To address this issue, the Commonwealth's Criminal Justice Planning Agency (CJPA) will work together with the Office of the Governor, the Office of the Attorney General, the CNMI Legislature, and law enforcement agencies responsible for arresting or detaining individuals to develop legislation that complies with the Death in Custody Reporting Act (DCRA) under Public Law 113-242. Enacting this legislation will create an incentive for law enforcement and criminal justice entities to comply with the federal mandate, resulting in complete and accurate reporting of DCRA data. CJPA will rely on quarterly reports from the Department of Public Safety and the Department of Corrections regarding any violations of the Death in Custody Reporting Act.

The Commonwealth of the Northern Marianas Islands has only one level of state government. As such, Saipan has only one non-federal law enforcement agency, the Department of Public Safety. The CNMI has no municipal or county jails or lock-up facilities, contract prisons, or state-run/contract boot camp facilities. The Department of Corrections (DOC) manages two facilities in the Northern Mariana Islands (CNMI): the Saipan Correctional Facility (SCF) and the Rota Jail. The SCF is the primary facility, accommodating the majority of inmates, while the Rota Jail is a smaller facility serving the municipality of Rota. The DOC has a maximum capacity of 250 inmates and houses both male and female offenders, with drug-related offenses being the most common reason for incarceration. Inmates also commonly commit offenses such as assault, theft, and robbery.

The Saipan Correctional Facility is a state-run institution that can house up to 200 inmates. This facility primarily houses individuals who have committed drug-related offenses and those who have been convicted of crimes such as assault, theft, and robbery. In addition to these individuals, the Saipan Correctional Facility houses several inmates awaiting trial.

The Rota Jail is another state-run correctional facility in the Northern Mariana Islands. This facility has a maximum capacity of 50 inmates. It accommodates individuals who have

committed similar crimes as those housed in the Saipan Correctional Facility, such as drug-related offenses, assault, theft, and robbery. The Rota Jail also houses inmates who are awaiting trial.

Both facilities are managed by the Department of Corrections, which is committed to improving its programs and facilities to rehabilitate inmates better. The department offers a range of programs, including educational, vocational training, and substance abuse treatment programs. By providing these programs, the Department of Corrections aims to help inmates gain the skills they need to re-enter society successfully.

It is essential for the Department of Corrections to have strong ties with the community, and they are working towards achieving this by partnering with local organizations to support inmates after they are released. This will help provide inmates with the necessary resources to succeed, reducing recidivism rates and improving public safety.

To ensure that the Department of Corrections achieves its goals, it must regularly report data and statistics about what is happening in its correctional facility. This information can be obtained from each inmate intake log, which collects essential information about an inmate's demographic, criminal, medical, and mental health history. Additionally, incident reports are filed whenever an incident occurs in the facility, such as an assault, fight, or suicide attempt. These reports provide details about the incident, including the date, time, location, and involved parties. By regularly reviewing this information, the Department of Corrections can identify areas that need improvement and make necessary changes to their programs and facilities.

- **Law enforcement agencies that are not actively participating in the DCRA data collection:**

Through recent clarification with the DCRA Office, the Bureau was informed that all law enforcement agencies, jails, prisons, and juvenile detention facilities are required to report on the DCRA regardless of whether they are Byrne JAG recipients or not. The following are agencies that are not actively participating in the DCRA data collection: the Judiciary

of the Northern Marianas Islands Marshalls Division, CPA Airport Police, Customs & Biosecurity.

To ensure that we continue to meet the reporting requirements under P. L. No. 113-242, CJPA will initiate communication with the NMI Judiciary for assistance in providing information that outlines or guides the process of how the Judiciary will collect and report the DCRA information to the Bureau. Following the approval of the CNMI's DCRA State Implementation Plan, the Bureau will move forward to coordinate with the the Judiciary of the Northern Marianas Islands Marshalls Division, CPA Airport Police, Customs & Biosecurity to enter into an Interagency Agreement to allow the process of reporting DCRA data on a quarterly basis regardless of whether a death-in-custody occurred while in custody. Following the establishment of the Interagency Agreement with law enforcement agencies, CJPA will continually update the DCRA State Implementation Plan and will provide the updated plan to all reporting law enforcement agencies to keep appraised of policies and procedures to ensure complete decedent records are reported to CJPApromptly.

- **Implementation Plan of DCRA:**

The CNMI Department of Corrections (DOC) must uphold its responsibility to submit a comprehensive report to the CJPA every fiscal quarter. This report must be completed promptly, by five (5) days after the end of each quarter, or as frequently as requested by the CJPA. The accuracy and timeliness of these reports are crucial to ensuring the effectiveness and accountability of the correctional system.

- **Methods used for collecting reportable death data from the reporting entity:**

The Bureau of Justice Assistance has developed a template for the Death in Custody Reporting Act which is used to collect and report specific data fields and measurements as mandated by the public law. Reporting agencies must report these required data fields to the Bureau, which will then be submitted in the Performance Measurement Tool (PMT). The report required by this section shall contain information that, at a minimum, includes:

(1) the name, gender, race, ethnicity, and age of the deceased;

(2) the date, time, and location of death;

(3) the law enforcement agency that detained, arrested, or was in the process of arresting the deceased; and

(4) a brief description of the circumstances surrounding the death (34 U.S.C. § 60105(b)).

➢ **The following are the methods for collecting reportable death data from the CNMI Department of Public Safety and the CNMI Department of Corrections.**

➢ **<u>Department of Public Safety</u>**

Section IV(G) "Incident Notifications" and Section V "Procedures-Preliminary Death Investigation" of the Uniformed Services SOP. There are no specific written operation procedures that address Death of a person detained, arrested or in the custody of Police. Please see attached SOP.

V. PROCEDURES - Preliminary death investigations

A. Preliminary Death Investigations

1. After arriving at the scene and until convinced to the contrary, all officers should consider every unattended death call as a possible homicide.

2. Officers shall, as circumstances permit, check the victim's vital signs (breathing, pulse, muscle reflexes). Further, officers shall ensure the safety of any other persons in the vicinity, as necessary, to prevent injury or death. Unless the person is obviously dead, officers shall summon EMT personnel to establish the fact of death. In the death report, officers shall note the name of the EMT and his or her identification number, and arrival time.

B. Procedures:

1. Responsibilities of first officer on scene.

Before moving the corpse:

a. Preserve the scene and possible evidence.

b. Request a supervisor. Have dispatch contact the medical examiner, if appropriate.

c. Take photographs of the body and the immediate area. Carefully note the body's position and the presence of any objects near the body, particularly toys if the corpse is a child.

d. Identify and interview witnesses.

3. If death appears to be the result of natural causes, contact the victim's physician and family (if possible) to determine medical history.

a. The death may be treated as natural without notification of the medical examiner if the victim's physician agrees to sign the death certificate, or the attending physician in a hospital or nursing home, or a registered nurse in a hospice, agrees to do so.

b. All deaths must be pronounced by a physician or a qualified EMT which may happen at the scene, at a hospital, or any other place designated by the medical examiner in medical examiner cases. The officer shall include in his or her report the time of pronouncement, the name of the physician, and where the body is to be taken.

4. Medical examiner's case

If the circumstances of death fall into any of the following categories, or if there is any doubt as to the death's inclusion in one of these classifications, it shall automatically be considered a medical examiner's case.

a. Classifications

i. By violence; that is, accident, trauma, fire, injury, poisoning, suicide, or homicide.

ii. Suddenly, when in apparent good health.

iii. When unattended by a physician.

iv. When in jail or in custody.

v. By unusual, suspicious, or unnatural means.

vi. Sudden death of an infant under eighteen months of age whose death is suspected to be attributable to Sudden Infant Death Syndrome.

5. Non-medical examiner's case

For the purposes of these procedures, a non-medical examiner's case shall be defined as:

a. A death resulting directly from a disease or illness, which has been diagnosed and is actively being treated or attended to by a private physician.

b. The death is not within the classification of a medical examiner's case, as defined above.

6. When the medical examiner is not immediately available.

a. If authority for removal of the body cannot be ascertained from the medical examiner within a reasonable period of time, the Investigator or medical personnel (EMS), acting as an agent for the medical examiner, may have the body transported to the nearest hospital for pronouncement and custody.

b. The assistance of the fire department may be requested in emergency situations requiring the immediate removal of a body.

c. Under no circumstances shall officers transport dead bodies.

C. Childhood Death Procedures

In the event that the death victim is a child, officers shall obtain and document the following information (not necessarily available at the scene) in addition to the measures outlined above:

1. List the other people who reside at the victim's residence (noting their age, sex, relationship, and state of health).

2. Conduct records checks on other family members.

3. Contact the Department of Social Services and obtain any records on the child or his or her family.

4. For an infant, ascertain what prenatal care the mother received, the name/address of the delivering physician, and the name/address of the current physician.

5. Ascertain if the child had been taking medication and whether he or she had shown any symptoms before death.

6. Ascertain whether any other household members were recently ill or injured.

7. Ascertain the child's diet and what and when the child last ate.

8. Ascertain who last saw the child well, and whether death was observed.

9. Document any suspicious fumes or odors in the house.

10. If the child sleeps with another person, obtain as much background information about that person as possible.

D. Death Notification

Note that timeliness takes precedence over protocol when giving a death notification. The officer shall notify, or cause to be notified, the next-of-kin as soon as possible. The notification should be done in person.

❖ **Department of Corrections**

I. PURPOSE

To establish procedures that will be used by staff in the event of inmate/detainee's illness or death.

II. POLICY

It is the policy of the Department of Corrections (DOC) to ensure proper actions are taken and notification of the inmate/detainee's next of kin in the event of illness or death.

III. PROCEDURES

Inmates/detainee's illness or death is of immediate concern to the inmate's/detainee's family. The name of the inmate/detainee's next of kin will be obtained at the time of admission. In the event of an inmate/detainee's illness or death, the individuals so designated as the next of kin will be notified immediately.

A. Inmate Death

In the event of an inmate/detainee's death in the DOC, the officer discovering the dead person will do the following:

1. Remain at the scene; secure the area, DO NOT TOUCH ANYTHING, and call the Shift Commander immediately.

2. Report to the Shift Commander all pertinent information regarding the dead person.

3. Shift Commander will report the incident to DPS central and then wait for CIB to conduct the necessary investigation, preserving the scene from contamination. The Lead Detective will control the scene immediately upon arrival.

4. Isolate the dead person from all inmates/detainees by securing them in their cells. Staff will not touch or move the body from where it is found.

5. Write and submit a self-statement regarding the incident immediately to the Shift Commander.

6. Cooperate with investigators, including allowing medical personnel or other experts deemed necessary for the purpose of processing the scene.

7. Inventory on the decedent's property will be made.

B. Inmate Death Notification

In the event an inmate/detainee dies or is seriously ill, the Shift Commander will contact and brief the following as to the name of the inmate/detainee, date, time, and actions taken:

1. Commissioner of Corrections
2. Director of Corrections
3. Deputy of Corrections
4. Operations Captain

C. Notification of the Next of Kin

1. The Commissioner of Corrections or his/her designee will notify the inmate's/detainee's next of kin in the event an inmate/detainee dies.

2. When an inmate/detainee is seriously ill, the Shift Commander will notify the next of kin of the inmate/detainee. Before notifying the next of kin, the inmate/detainee's consent will be obtained.

D. Shift Commander duties in the event of inmate/detainee death

The Shift Commander will do the following in the event of an inmate's/detainee's death in the facility:

1. Notify the individuals listed above, i.e., Commissioner, Director, Deputy Director, and Operations Captain.
2. Call DPS Central and report the incident.
3. Call the Fire Division and request for an emergency medical technician.
4. A Doctor from CHC will be requested to be present at the scene.
5. Ensure that the body is not touched or removed.
6. Ensure that all inmates/detainees are secured.
7. Secure all gates and limit access to the facility to essential personnel.
8. Request additional corrections officers if necessary.
9. Ensure that all reports are submitted to the Operations Captain as soon as possible.
10. A copy of the final report is submitted to the Commissioner of Corrections and a copy is placed in the inmate/detainee's medical record.