S. Hrg. 117–536

UNCOUNTED DEATHS IN AMERICA'S PRISONS AND JAILS: HOW THE DEPARTMENT OF JUSTICE FAILED TO IMPLEMENT THE DEATH IN CUSTODY REPORTING ACT

HEARING

BEFORE THE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
OF THE

COMMITTEE ON
HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

SECOND SESSION

SEPTEMBER 20, 2022

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Committee on Homeland Security and Governmental Affairs

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CONTENTS

WITNESSES

TUESDAY, JULY 26, 2022

ALPHABETICAL LIST OF WITNESSES

APPENDIX

UNCOUNTED DEATHS IN AMERICA'S PRISONS AND JAILS: HOW THE DEPARTMENT OF JUSTICE FAILED TO IMPLEMENT THE DEATH IN CUSTODY REPORTING ACT

TUESDAY, SEPTEMBER 20, 2022

U.S. SENATE,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS,
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:30 p.m., in room 342, Dirksen Senate Office Building, Hon. Jon Ossoff, Chairman of the Subcommittee, presiding.

Present: Senators Ossoff, Hassan, Padilla, Johnson, and Scott.

OPENING STATEMENT OF SENATOR OSSOFF[1]

Senator OSSOFF. The Permanent Subcommittee on Investigations (PSI) will come to order.

Today, the Subcommittee continues our bipartisan work investigating conditions in prisons, jails, and detention centers across the United States. I thank the Ranking Member for his cooperation.

In July, we released findings of corruption, abuse, and misconduct in the Federal prison system, and questioned the now-former Director of the Federal Bureau of Prisons (BOP). Today, after a 10-month bipartisan investigation, we can reveal that despite a clear charge from Congress to determine who is dying in prisons and jails across the country, where they are dying, and why they are dying, the Department of Justice (DOJ) is failing to do so. This failure undermines efforts to address the urgent humanitarian crisis ongoing behind bars across the country.

Our investigation has revealed that last year alone, according to the Government Accountability Office (GAO) analysis that I requested, the Department of Justice failed to identify at least 990 deaths in custody, nearly 1,000 uncounted deaths, and the true number is likely much higher.

We will hear today from Belinda Maley and Vanessa Fano, whose loved ones died preventably while in custody—in both cases, sons and brothers who died while they were pretrial detainees, having been convicted of no crime. We will hear their grief and

[1] The prepared statement of Senator Ossoff appears in the Appendix on page 37.

anger, a grief and anger shared by many thousands of Americans whose loved ones needlessly suffered and died while incarcerated.

We will hear from Professor Andrea Armstrong of Loyola University New Orleans to understand why and how DOJ's failure to oversee prisons and jails undermines Americans' civil rights.

We will hear from Dr. Gretta Goodwin of the Government Accountability Office, a legislative branch agency that provides investigative services to Congress, which analyzed at my request the death in custody data that DOJ collected in 2021, and who will publicly report those findings today for the first time.

We will question Ms. Maureen Henneberg, Deputy Assistant Attorney General, about the Department's failure since 2019 to implement the Death in Custody Reporting Act (DCRA), a failure that has undermined Federal oversight of conditions in prisons and jails nationwide, and therefore, undermined Americans' human and Constitutional rights.

Members of Congress swear to "support and defend the Constitution of the United States," to defend the constitutional rights of all Americans, in my State and every State, including the rights of those who are incarcerated.

We are here today because what the United States is allowing to happen on our watch in prisons, jails, and detention centers nationwide is a moral disgrace. As Federal legislators serving on the nation's preeminent investigative panel, it is our obligation to investigate the Federal Government's complicity in this disgrace.

Therefore, it is our obligation to ask what tools the Department of Justice is using to protect the Constitutional rights of the incarcerated, to hold DOJ accountable when it fails to use those tools, and to furnish better, more powerful tools with which the Department can defend civil rights and civil liberties.

There are some bright spots. For example, I was encouraged when Assistant Attorney General Kristen Clarke announced a DOJ investigation of conditions in Georgia's horrific State prisons almost one year ago today.

But it has become clear in the course of this investigation that the Department is failing in its responsibility to implement the Death in Custody Reporting Act, that is, the Department is failing to determine who is dying behind bars, where they are dying, and why they are dying, and therefore failing to determine where and which interventions are most urgently needed to save lives.

In 2000, and then again in 2014, Congress passed the Death in Custody Reporting Act, tasking DOJ with the collection and analysis of custodial death data nationwide. DOJ itself describes this law as, quote, "an opportunity to improve understanding of why deaths occur in custody and develop solutions to prevent avoidable deaths."

For nearly 20 years, DOJ collected and published this data, an invaluable resource for the Department, for the Congress, and for the public. Then, abruptly, that publication stopped, and our investigation followed.

We found that in recent years, and over multiple administrations, the Department's implementation of this law has failed, despite clear internal warnings from DOJ's own Inspector General (IG) and DOJ's Bureau of Justice Statistics (BJS).

For example, in the first quarter of fiscal year (FY) 2020, the Department did not capture any State prison deaths in 11 States or any jail deaths in 12 States and the District of Columbia. In fiscal year 2021 alone, according to GAO analysis produced at our request, the Department failed to identify nearly 1,000 deaths, and my assessment is the true number is likely much higher. Of those recorded, 70 percent of the records were incomplete, and 40 percent of records failed to capture the circumstances of death.

The Department of Justice has failed to collect complete or accurate State and local death data for the past 2 years, and failed to report to Congress how data about deaths in custody can be used to save lives, a report required by law that is now 6 years past due and, we recently learned, is not expected to be produced for another 2 years.

PSI's investigation also found that the Department has no plans to make State and local death data public again, despite the obvious public interest in this transparency.

Now today's hearing may dive at times into arcane discussions of administrative regulations or the close parsing of legislative text, and those discussions are relevant.

If the Department has concluded in 2022, 8 years after this law was reauthorized, that it is incapable of successfully implementing it, I am surely willing to work with them to help fix that.

But this hearing is about something more fundamental. Americans are needlessly dying, and are being killed, while in the custody of their own government. In our July hearing focused on the Federal prison system, we revealed that Federal pretrial detainees have been denied proper nutrition, hygiene, and medical care; endured months of lockdowns with limited or no access to the outdoors or basic services; and had rats and roaches infesting their cells.

We revealed that Federal inmates killed themselves while the basic practices of suicide prevention and wellness checks were neglected—abusive and unconstitutional practices by the Federal Government that likely led to loss of life in Federal facilities.

We revealed that the Bureau of Prisons, an agency of the Department of Justice, was warned for years by its own investigators of corruption and misconduct in its own facility, of a "lack of regard for human life" by its own personnel.

Today, we will hear about the experiences of Americans in State and local prisons and jails, Americans entitled to Constitutional rights no matter whether they are incarcerated, no matter whether they are incarcerated. We will hear about Americans who died in custody, many of whose deaths and causes of death are not being counted by the Federal Government, as the Federal Government is bound to count them. The same Federal Government obligated to defend their constitutional rights.

Before I yield to the Ranking Member, and with Ms. Maley's permission, we are going to listen to an audio clip of the last phone call that she shared with her son while he was jailed, a pretrial detainee who was never convicted of any crime.

I want to warn those who are tuned in across the country that this is a disturbing clip. While this audio plays, I ask that we imag-

ine how we might feel to be on either end of this call. Please play the audio.

[Beginning of Audio Recording.]

Mother: Matthew?

Loflin: Hey.

Mother: OK, listen I found out everything I can. I am going to try to get . . . um, I am having lawyers and the sheriff and all this other kind of shit trying to make it so I can come in there and see you. I am trying also to get you out of there and get you——

Loflin: I need to go to the hospital.

Mother: I know.

Loflin: I am gonna die in here.

Mother: I know you are, Matthew. I am doing everything I can to get you out, and so I can see you. Hello?

Loflin: Yes.

Mother: They are doing everything they can.

PHONE: There are 15 seconds remaining.

Loflin: I have been coughing up blood and my feet are swollen. It hurts, Mom.

Mother: I know Matthew, I know what is wrong with you. I told you this would happen. I love you, Matthew. They are going to cut us off . . .

Loflin: I love you too. I am gonna die in here.

[End of Audio Recording.]

Senator OSSOFF. The crisis in America's prisons, jails, and detention centers is ongoing and unconscionable. The Department of Justice and the Congress must treat this as the emergency to constitutional rights that it is.

Senator Johnson, I yield to you.

OPENING STATEMENT OF SENATOR JOHNSON

Senator JOHNSON. Thank you, Mr. Chairman. You are correct. That is very difficult to listen to. Ms. Maley, Ms. Fano, our sincere condolences for the loss of your loved ones. I cannot imagine how difficult it is for you to listen to that.

First of all, let me enter my prepared opening remarks into the record.[1] Much of what I prepared would be a repeat of what the Chairman just laid out.

I think many people might question what equity does the Federal Government have in how State and local governments run their prisons. I think we just heard the equity right there.

As the Chairman laid out, there are issues of civil rights and basic civil liberties, the presumption of innocence, the right to fair trial, a speedy trial, and the rights to be given proper care when in custody.

I want to commend the Chairman for doggedly pursuing the truth here. I think you are certainly experiencing the frustration I have experienced as chairman of the full Committee doing investigations, and simply having the departments and the agencies pretty well ignore our oversight requests.

The American people deserve the truth here. The American people deserve to understand what is happening in Federal Govern-

[1] The prepared statement of Senator Johnson appears in the Appendix on page 41.

ment agencies. I do not know whether these things can be prevented from more rigorous Federal Government oversight, congressional oversight, exposure, but it is just the right thing to do.

Mr. Chairman, I appreciate your pursuit of these truths. I have certainly been appreciative of the fact that we have been able to work on this cooperatively. Specifically in terms of this issue right here, I think it is interesting. The original law passed in 2000 did produce information. I have a report that is 40-some pages long. It is chock full of information. I know it expired, but the Department of Justice continued to provide this information to inform Congress, inform the American public.

Then Congress changed the law, they updated the law, and put funding attached to it with penalties. Then something went haywire. You are talking about the exact legislative text, which agency can collect the data versus one that cannot. It is all bureaucratic BS, if you ask me, but it happened, and so we lost the transparency. It does not look like the Department of Justice is particularly interested in providing that transparency now, and that is serious issue. I do not understand it.

But listen, I am going to continue to cooperate with you to try and get those answer because I think Ms. Fano, Ms. Maley, I think you deserve those answers, and hopefully some of this congressional oversight can do more than assist us in passing new laws. Hopefully it can save lives. I wish that could have been the case with your loved ones.

Thank you, Mr. Chairman.

Senator OSSOFF. Thank you, Ranking Member Johnson.

The Subcommittee's findings, which form the basis for today's hearing, are laid out in a bipartisan staff report, and I ask unanimous consent that this report be entered into the record.[1]

We will now call our first panel of witnesses for this afternoon's hearing. Ms. Vanessa Fano is the sister of Jonathan Fano, who died in the East Baton Rouge Parish Prison in Louisiana. Mrs. Belinda L. Maley, is the mother of Matthew Loflin, who died in the Chatham County Detention Center (CCDC) in Georgia. Professor Andrea Armstrong is a Professor of Law at Loyola University, New Orleans College of Law.

The Subcommittee is deeply grateful for your presence, testimony, and courage in appearing today. We look forward to your testimony. The hearing record will remain open for 15 days for any additional comments or questions by Members of the Subcommittee.

The rules of the Subcommittee require all witnesses to be sworn in, so at this time I would ask you to please stand and raise your right hand.

Do you swear that the testimony you are about to give before this Subcommittee is the truth, the whole truth, and nothing but the truth, so help you, God?

Ms. FANO. I do.

Ms. MALEY. I do.

Ms. ARMSTRONG. I do.

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[1] The Staff Report appears in the Appendix on page 309.

Senator OSSOFF. Thank you. The record will reflect that all witnesses answered in the affirmative. Please be seated.

Your written testimonies will be printed for the record in their entirety. We ask that you try to limit your remarks to around 5 minutes.

Ms. Fano, we will hear from you first, and you are recognized for your opening remarks. A kind reminder to all three of you, when addressing the Subcommittee please make sure that your microphones are on, as indicated by the red light. Thank you, Ms. Fano.

TESTIMONY OF VANESSA FANO,[1] SISTER OF JONATHAN FANO, WITNESS' BROTHER DIED IN THE EAST BATON ROUGE PARISH PRISON IN LOUISIANA

Ms. FANO. Thank you, Chairman Ossoff and Ranking Member Johnson, for the opportunity to testify before you today, and thank you to the Committee staff whose tireless work made my appearance possible here today.

No amount of time can truly heal what I share with you today.

Jonathan Louis Fano is my brother. Jonathan was so kind. He felt guilty even so much as killing a bug. He once took the bus downtown just to babysit our cousin's kids, even though it was his own birthday. Jonathan would spend hours upon hours listening to my problems and would do anything to support me. But at the time he needed the same support, no one responsible for his care, custody, and control gave it to him.

Jonathan suffered from bipolar disorder and depression, for which he sought professional help and support from his family. He was never any type of threat or danger to us or to others.

In October 2016, Jonathan was arrested in Baton Rouge, Louisiana, while having a mental breakdown, and taken to East Baton Rouge Parish Prison. In his 10 weeks in pretrial detention, Jonathan never received a mental evaluation. After cutting his wrists he was placed in isolation.

Despite our frequent phone calls, our family was repeatedly told that Jonathan did not want to speak to us. It was only on Christmas that we heard from him. Jonathan told us he was not allowed to call us. During that phone call, we learned about Jonathan's attempt on his own life. We could not get the details before the for-profit phone system cut off our call. Even though we provided more funds, we were not able to continue the call.

We trusted the system. My family trusted the system when it provided us Jonathan's court date. My family flew across the country only to discover we were provided the wrong date. We trusted his public defender would be advocating for Jonathan's mental health, care, and release, and the advice to wait just a little longer in custody to resolve the case. We trusted the Baton Rouge's Sheriff's Office, who confirmed Jonathan was receiving the care he needed in detention.

On February 21, 2017, Jonathan hanged himself with a bedsheet in his cell. When we finally saw his lifeless body the first time in 10 weeks he was handcuffed to an intensive care unit bed. It was only then we realized how wrong we were to place our trust in this

[1] The prepared statement of Ms. Fano appears in the Appendix on page 42.

system, which told us there was no fault after their own internal investigation of Jonathan's death.

It is only through our own insistence over the past 5 years that we have come to learn how hard Jonathan tried to receive help, how belittled he was, how no one believed him, how so many other people have died in the same jail, under the same conditions.

Each time I tell Jonathan's story he feels farther away. I worry for the day where I cannot distinctly remember his voice or his warmth or even his face.

I tell you Jonathan's story for every family who has experienced the same, and I hope in doing so we can improve our beloved nation and prevent this from ever happening to another family again.

Please accept my respectful request to enter further written testimony into the record. Thank you.

Senator OSSOFF. Thank you, Ms. Fano, and the rest of your written testimony will be so entered, without objection. Thank you for your testimony.

Ms. Maley, we will now hear from you. Do not feel bound by the precise time on the clock. We will accommodate the time you need to share your story, and you are recognized for your opening statement.

TESTIMONY OF BELINDA L. MALEY,[1] MOTHER OF MATTHEW LOFLIN, WITNESS' SON DIED IN THE CHATHAM COUNTY DETENTION CENTER IN GEORGIA

Ms. MALEY. Thank you, Chairman Ossoff, and Ranking Member Johnson, for the opportunity to testify before you today, and thank you to Committee staff whose work made my appearance here today possible.

Mothers and sons have a special bond, a bond that no one should ever be able to break. Tragically, in my case, that bond was broken. It was broken by a for-profit medical provider that brought a painful death on my only son, my only child.

My son, Matthew, was scared and alone in the Chatham County, Georgia, Detention Center on a nonviolent drug offense. Matthew was suffering from cardiomyopathy, which the for-profit medical provider ignored. Studies show that the prognosis for people with untreated cardiomyopathy is bleak, and Matthew was never given any treatment. The for-profit medical provider had no intentions of treating him because cardiology appointments outside of the jail would cut into their profit margin.

One of his jailers called his pain and anguish, "fussy." Matthew knew he was dying. He told me many times by phone and in a single jail visit that, "I needed to get him out of here" and that he "did not want to die here." The pure horror of Matthew's voice made me feel as though I was dying as well.

Matthew died a slow, painful death over the course of weeks. He was too sick to take phone calls or visits after the one time I got to see him in jail. I never got to hold him, to tell him how much I loved him, or pray with him. The next time I got to see Matthew he had already suffered brain injury after being resuscitated three times by the jail staff.

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[1] The prepared statement of Ms. Maley appears in the Appendix on page 149.

My last visit with him was to take him off of life support, where he was still handcuffed to an intensive care unit (ICU) bed and under 24/7 supervision by a corrections officer. After 32 years of life with my only son, our bond was broken, and no one, not the health provider, not the infirmary staff, the Sheriff's Office, or the district attorney, was willing to help.

They did take time to exact one last indignity upon Matthew before his death, issuing him a personal recognizance bond after he was brain dead, so his death would not count as an in-custody death. Not a day goes by that I do not think of what Matthew went through.

In closing, Matthew's story might not be over. I will continue to spread awareness of this problem for as long as I am able. With over two million people in our prisons and jails, there are more millions of mothers, fathers, siblings, and friends who are in this same or worse situation. This should not be ignored. That is why enforcement of the Death in Custody Reporting Act is so important and could be a tool to hold the for-profit jail and prison medical providers accountable for unnecessary deaths, like Matthew's and others.

I ask respectfully to enter further written testimony into the record. Thank you.

Senator OSSOFF. Thank you, Ms. Maley, and without objection your written testimony will be so entered into the record. Ms. Fano and Ms. Maley, thank you for sharing your difficult, deeply personal stories with the Subcommittee.

Professor Armstrong, you are now recognized for five minutes to present your opening statement.

TESTIMONY OF ANDREA ARMSTRONG,[1] PROFESSOR OF LAW, LOYOLA UNIVERSITY NEW ORLEANS COLLEGE OF LAW

Ms. ARMSTRONG. Chairman Ossoff, Ranking Member Johnson, and Members of the Subcommittee, thank you for holding this hearing and for the opportunity to testify. Thank you also to the staff who worked incredibly hard to pull this together as well as the courage of the families who are appearing as witnesses today.

My name is Andrea Armstrong, and I am a law professor at Loyola University, New Orleans. I teach in the areas of criminal and constitutional law, and I research incarceration law and policy. I have visited prisons and jails across the country, and I participate in audits of these facilities for their operations and adherence to best practices.

My students and I created incarcerationtransparency.org. It is a project and a website that collects, publishes, and analyzes deaths in custody in Louisiana prisons, jails, and detention centers. At the time that we started that project, and continuing today, the type of information that we wanted was not available, namely individual-level death records as well as facility-level death records, so that we could identify which facilities in Louisiana were actually the most troubled.

As we heard today from other witnesses, there are a lot of reasons to be concerned when a death in custody occurs. In addition

[1] The prepared statement of Ms. Armstrong appears in the Appendix on page 200.

to the impact on families and communities, deaths in custody may signal broader challenges in a facility. It is impossible to fix what is invisible and hidden. As Justice Brandeis wrote, "Sunlight is the best of disinfectants; electric light the most efficient policeman." Increasing public transparency on deaths in custody is a critical step toward ultimately reducing deaths in custody.

I would like to share with you a graph[1] that I shared with your staff, and it is on page 28 of Exhibit 1. This chart helps us understand why transparency is so critical. The percentage of suicides that happened in solitary confinement, also known as isolation, restrictive housing, or segregation, is highlighted in pink. What you can see is we are looking at the location of suicides by the type of facility. The first column is Department of Corrections—those are prisons—the second is juvenile facilities, the third is jails that are locally operated, and the fourth is private.

What you can see in pink is that 43 percent of all suicides in Louisiana jails occurred in solitary confinement. Compare that to only 7 percent in our State prisons. Of the 3 youth suicides that happened between 2015 and 2019 in Louisiana, 2 out of 3 occurred when these youth were confined, alone, and in segregation.

This finding should prompt review of staffing, discipline, security, and mental health protocols in the jails where the suicides occurred. But unfortunately, due to changes in the Federal collection of data on deaths, we will no longer be able to identify patterns like these. That is because the Department of Justice no longer collects information on incident locations within a prison or jail. It also does not collect information from facilities where there were zero deaths, meaning it will be harder for facilities to learn from each other what works and what does not work.

Changes in what is collected is not the only problem. In addition, the Department of Justice is undercounting deaths. For deaths in 2020, Louisiana reported 6 total deaths to the Bureau of Justice Assistance (BJA). In contrast, Loyola law students identified 180 deaths in 2020 in Louisiana prisons and jails, and multiple sheriffs informed our students that they were no longer required to report deaths in custody for Federal data collection. If Louisiana's experience is similar to those of other States, 2020 will be the first year in almost two decades in which the Department of Justice cannot tell us who is dying behind bars and why.

Congress has a range of tools available to help increase transparency, which ultimately, I hope, will reduce in-custody deaths. The work of your Committee is vital, and academic researchers like myself stand ready to assist and to support as needed.

Thank you.

Senator OSSOFF. Thank you, Professor Armstrong, and thank you again to all three for your powerful testimony today. I will begin with questions, and I would like to begin with you, Professor Armstrong, unless Senator Padilla, do you have an imminent——

Professor Armstrong, I would like to begin with you. Explain how deaths in custody, as data, can be a proxy or an indicator for conditions in specific facilities.

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[1] The chart referenced by Ms. Armstrong is in her testimony that appears in the Appendix on page 200.

Ms. ARMSTRONG. What we know when we look at the data is we look for patterns in what is happening. For example, the slide that I shared on suicides, what that tells us that there are deep differences between where suicides are occurring, which makes me want to look at the policies that are in place. Were staff doing observation rounds near the areas of segregation? Discipline—why were people put in solitary confinement, and for what types of offenses, and for how long, because we know of the harmful effects of solitary confinement and ways in which it can be both create and aggravate existing serious mental illness, in many cases leading to suicide.

We also want to think about what are the mental health protocols. Are they doing the required visual checks? Are they doing the suicide watch observations that are required under best practices?

Deaths in that way can be the tip of the iceberg for understanding what is happening in that facility and their adherence to best practices.

Senator OSSOFF. Professor, you are the founder of Incarceration Transparency. What does this organization do, in a nutshell?

Ms. ARMSTRONG. It is more of a project than an organization, but it is my students and me. For the past 3 years now about 60 students, we collect, publish, and analyze individual-level records of death. But I think in terms of transparency, the goal is we have a searchable database where you can go and look up any record of death and try and understand what is happening at your local facility, in particular. It is often because of this database that family members reach out to me for information about the deaths of their loved ones.

Senator OSSOFF. Law students making public record requests are able to capture this data. Correct?

Ms. ARMSTRONG. Yes. Technically, you do not have to be a lawyer to file a public records request, but it certainly helps. My students do this every single year.

Senator OSSOFF. In your view, is this work that the Federal Government should be doing?

Ms. ARMSTRONG. Absolutely. It is me and 20 law students once a year. It would be much better if the Federal Government collected this level of information.

Senator OSSOFF. Therefore, indeed work that is eminently, or should be eminently within the capacity of the United States Department of Justice.

Ms. ARMSTRONG. Absolutely.

Senator OSSOFF. Thank you, Professor.

Ms. Maley, thank you again for sharing your family's personal tragedy with the public today. I would like to ask you what has motivated you to take this step?

Ms. MALEY. The biggest motivation, and it will serve no justice for my son—there is none—the biggest motivation I have is everyone knows somebody that is affected by drug use, alcohol use, mental illness, and sometimes pure carelessness, that could end with you being pulled over by your local law enforcement agents and put in jail. It is a horrible thing for me to think, maybe my next-door neighbor may be going to the store, and get pulled over for some-

thing. A minor infraction, as we all know, can put you in jail and jeopardize your life.

I would like some transparency. I would like to be able to know that our justice system is doing the right thing according to our health care providers in these institutions.

Senator OSSOFF. Thank you, Ms. Maley.

Ms. Fano, thank you as well for sharing your family's story, as difficult as I can imagine it must be, and for your powerful testimony. What is your message, or call to action for members of this Subcommittee, the Senate, and for the folks at the Department of Justice?

Ms. FANO. Had adequate care been given to my brother, Jonathan Louis Fano, I do believe that I would still have him in my life. I believe that if we provide the resources that are necessary to inmates who struggle with mental illness, far less tragedies will occur. It is a matter of acknowledging those mistakes and acknowledging that we can improve and be better so that such traumatic incidents will not occur, so that families will not have to deal with the horrible reality of rather than a loved one coming out of an institution more well-established and aware of how to integrate back into society, they come back in a casket.

I ask that we acknowledge our mistakes and move toward a better future for everyone.

Senator OSSOFF. Thank you, Ms. Fano. At this time, with the Ranking Member's permission, I will yield to Senator Padilla for his questions.

OPENING STATEMENT OF SENATOR PADILLA

Senator PADILLA. Thank you, Mr. Chairman. Thank you, Senator Johnson, for the accommodation. I have another meeting in a few minutes I need to get to. But I wanted to, first of all, thank you, Mr. Chair, for your ongoing diligence and oversight here, and I thank all three witnesses for participating.

I do have a couple of questions for Professor Armstrong, but I wanted to begin with Ms. Fano, not only as a follow-up to the Chairman's question. I guess the follow-up—and then I will share the personal—the follow-up is, so if some of the clear recommendations were to be followed and there is more transparency and more true data sharing, how could that help your family, so many other families across the country, who have experienced similar tragedies?

Ms. FANO. A big part of what occurred with our family involved our trust. Consistently, we were told to do things a certain way and that things were going correctly. We did not know how many incidents had occurred. Had we known, had we been disclosed the information of how horrendous the conditions are in that facilities and how few actually receive adequate care we would have insisted upon a different outcome.

A lot of our decisions came from pure trust toward our system, toward the appointed attorney, as well as the staff members at that correctional facility.

Should we change that? I do believe that other families might make the right decisions, might have more acknowledgment of the potential dangers, and with that acknowledgment can come change.

Senator PADILLA. Thank you. Thank you for sharing. Look, I know the data in front of us, the report that is being discussed spans from jails and folks that are pretrial to prisons, folks that have been convicted of a wide range of crimes, short sentences, long sentences, and everything in between. But that does nothing to take away fundamental human rights.

I mentioned a minute ago that there are a couple of personal comments I wanted to share, and it begins with applauding you for being so forthcoming with your concern about mental health and mental health conditions. My wife is a mental health advocate. Our family is big on making sure we are undoing stigma and raising awareness. It is one thing to talk about it in the post traumatic stress disorder (PTSD) in the military context. It is another when it comes to mothers suffering from postpartum depression, or in the higher education space, right, stress on college campuses.

Across the board, mental health was a big concern prior to the pandemic. We have all experienced a huge uptick during the Coronavirus Disease 2019 (COVID–19) pandemic, and it is important to recognize that whether it is jails, prisons, other institutions, there are no exceptions to that. Again, I come back to the human rights people deserve in terms of access to care, quality of care, and truth.

The other piece, you grew up not too far from where I grew up. Very similar communities. Your story resonates, and I appreciate your courage to be here and to share.

Professor Armstrong, following up on some of your work and some of the testimony you have submitted. In 2020, Reuters completed an investigation into how an estimated 5,000 people died in jails throughout the country in a single year, and that is jails. That is not counting prisons. These people died without ever having their case even heard at trial.

The data is sadly clear and compelling. The U.S. correctional system occupies a space where class, race, gender, and a host of other factors influence how long or how demanding your time in custody will be. However, pretrial time spent in a correctional facility should never be a de facto death sentence.

I noticed in your written testimony, and I will quote, "A lack of transparency on deaths in custody undermines our nation's commitment to public safety." Could you walk the Subcommittee through how a detailed accounting of deaths in custody would better inform our policymaking here in Congress?

Ms. ARMSTRONG. Absolutely. First, the nationwide data from 2000 to 2019 shows that 20 percent of deaths in custody were actually of people facing charges, meaning they had never had a trial. In Louisiana, 14 percent of our deaths were pretrial.

But think about it this way. If community members do not trust the policing, the sheriffs, the facilities, and the fact that our system is capable of delivering justice, they are less likely to report crime, they are less likely to serve as a witness or to provide testimony in a criminal trial, and they are less likely to themselves feel protected by those same systems when they are a victim of trial.

Public trust in our criminal justice institutions is fundamental. When we see the death penalty exacted without a judicial sentence, and where a person's probability of death is simply a factor of

which facility they are assigned to, that undermines their trust and it undermines all of our safety.

Senator PADILLA. Thank you. A final question. In your written testimony again you listed a number of suggested amendments that you believe could be useful for better collecting data. It is one thing to share data, but if you are not collecting it on the front end, that is another issue.

Among the suggestions you have made is that the Bureau of Justice Assistance collect information on incarcerated people's specific medical illnesses and preexisting conditions. Did you mean to include mental health conditions as well? Briefly elaborate on that.

Ms. ARMSTRONG. What we know from the prior, from BJS, right, so the earlier data, is they actually did collect mental health observation and practices, medical illnesses as well, although they only asked preexisting conditions for medical conditions. They did not ask for mental health.

When I proposed reverting back to those categories that we used to collect data on, yes, that would include mental health as well as medical health.

Senator PADILLA. Thank you very much. Thank you, Mr. Chair.

Senator OSSOFF. Thank you, Senator Padilla. Ranking Member Johnson.

Senator JOHNSON. Thank you, Mr. Chairman. Again, Ms. Fano and Ms. Maley, our sincere condolences. I cannot imagine how painful it is for you to have to relive this. I cannot imagine losing a child or a sibling, so again, thank you.

I want to try and find out, because it sounds like, in both of your cases, you were certainly not given the kind of contact you would want with a loved one in trouble. You were pretty well blocked out. Let us start there. While your son, while your brother were alive, how many times were you able to see them or talk to them. We will start with Ms. Fano. Approximately.

Ms. FANO. Of course. The only occasion where we were able to get a phone call through to my brother, after multiple attempts from multiple phone numbers, as my father, mother, siblings, myself had made attempts throughout the weeks, most likely every other day, essentially we would call and be told he did not want to call us. It was on Christmas. That was the only time that we ever received a phone call, and it was not even longer than 2 minutes.

Senator JOHNSON. His total time in custody was how long?

Ms. FANO. The total time in custody was from—can I just review?

Senator JOHNSON. Again, just approximately.

Ms. FANO. Ninety-one days.

Senator JOHNSON. Ninety-one days. You believe he did want to talk to you, though.

Ms. FANO. He had stated that he wanted to call.

Senator JOHNSON. You believe prison officials were simply lying to you.

Ms. FANO. My brother stated he had made attempts, and he had also written one letter to us, where he stated that he was not allowed to call us and he wanted to talk to us.

Senator JOHNSON. Ms. Maley, what about in your case? How long was your son in custody, and how many times—when he went into custody he already had this health condition. Correct?

Ms. MALEY. I am going to assume so because cardiomyopathy does not happen overnight. It is a condition that alcoholics and drug addicts get because of the wear and tear on your heart, your vascular system.

Senator JOHNSON. Right.

Ms. MALEY. With what I know and what I have investigated, untreated cardiomyopathy can advance rapidly. There are medications, which, it is not funny and I am shaking my head because it is unbelievable. It is also due to a fluid buildup, and people with heart issues and fluid retention issues are given a diuretic.

Senator JOHNSON. Right. Your son should be alive today. But again, were you aware of this condition when he went into custody?

Ms. MALEY. No.

Senator JOHNSON. OK. This was something that developed while he was in custody.

Ms. MALEY. Yes.

Senator JOHNSON. How many times were you able to see him or talk to him while he was in custody?

Ms. MALEY. One time I got to see him.

Senator JOHNSON. One time. This is over a span of how long again?

Ms. MALEY. Two and a half months.

Senator JOHNSON. Two and a half months. Now following the death of your son and your brother, who are you able to talk to within the prison system, within government? What conversations have you had? I will go back to Ms. Fano. You or your family members.

Ms. FANO. My mother and sister were actually able to see him one time, and they talked to the front desk staff. I am not quite sure the exact names for those individuals. Following when he hung himself we were in contact with numerous members from the facility, as they had to follow through with an investigation. I am not quite sure the exact names of all of those individuals, as my focus at the time was more on my brother rather than retaining those names.

But we were in contact with those individuals following him hanging himself. The most consistent contact we had with that facility was after he had done that.

Senator JOHNSON. Do you feel they gave you information, did they give you answers to what happened? Let me cut to the chase. Did they show compassion?

Ms. FANO. No.

Senator JOHNSON. You did not get any information. It was pretty well——

Ms. FANO. They had called us. Because we are in L.A., they had an Los Angeles Police Department (LAPD) officer come, and the LAPD officer had a phone with him, and the other individual on the other line only spoke English. My mother speaks Spanish. He bluntly stated, "Your brother hung himself." I asked him, "Is he going to be all right?" He said, "You have to get here. He most like-

ly is not." I asked for more details but he stated they were going under investigation at this time.

When we arrived, my mother and I were the first to arrive, and there was on all fronts, no compassion whatsoever. The individual who was guarding him had no compassion. The staff member who led us to the facility had no compassion, just presented us to his body, connected to multiple wires and machines that assured he could still function bodily wise. They stated that only his brainstem was functional, due to how long he had hung himself and how little oxygen his brain had received. Every other part of him, every bit of him that would retain memory, that was him essentially, was no longer present.

Senator JOHNSON. I am sorry to ask you to relive this. I really am. I wish I did not have to do this.

Following that horrible day, did you have further conversations with any officials, or was that pretty much your last contact?

Ms. FANO. We stayed a few days as we were waiting for magnetic resonance imaging (MRI) results, so they were in a bit of contact with us. There was always security by his bedside. He was handcuffed to the bed, despite the results of him being brain dead. At the time of passing, a staff member had to be in the room with us to ensure he did die. I do believe that we had to even wait for him to come, even though we were all present and ready. We had to wait for him.

Following this, we received a call. I am unsure of how many days later or maybe it was a few weeks, but we received a call stating that they had found that there was nothing that went wrong, that the investigation was just about clear. They did nothing wrong with his case.

Following this, my family and I could not accept this and we sought more information and an investigation by our own means. But the last real statement that they said to us was that they did nothing wrong.

Senator JOHNSON. They played it by the book.

Ms. FANO. Yes.

Senator JOHNSON. Mr. Chairman, would you like me to continue this?

Senator OSSOFF. Yes.

Senator JOHNSON. Reluctantly. Ms. Maley, have you talked to authorities following the passing of your son?

Ms. MALEY. No.

Senator JOHNSON. No authorities whatsoever?

Ms. MALEY. No, sir.

Senator JOHNSON. Nobody reached out to you?

Ms. MALEY. No, sir.

Senator JOHNSON. Have you tried to contact people?

Ms. MALEY. They ignored our phone calls. The only person that talked to us was before he passed. The only person that told us anything, and very little at that, was the man that worked for health care. I would call there every day, maybe twice a day, to check on him, and his only response was, "He has 24-hour care and he is doing fine."

Senator JOHNSON. He tried to reassure you.

Ms. MALEY. Excuse me?

Senator JOHNSON. He tried to reassure you, basically.

Ms. MALEY. Yes, sir, which now I know that that was not true.

Senator JOHNSON. No expression of sympathy, no demonstration of any compassion whatsoever, in either one of your cases.

Ms. MALEY. No, sir.

Senator JOHNSON. I do not have any further questions right now.

Senator OSSOFF. Thank you, Senator Johnson. In part, Ms. Fano and Ms. Maley, I think that the Subcommittee should help, in so far as we can, to honor and to remember Jonathan and Matthew, and their lives are having an impact here today, that I hope the Ranking Member and I will work together to ensure results and change.

In remembering and honoring their lives, Ms. Fano, can you tell us a little bit more about Jonathan, what he was like, what he loved, how he lived.

Ms. FANO. Jonathan was my older brother, and with that he was very protective of me. Any time I had problems he would talk to me about things and give me tips and tricks on how to go about school projects and how to make new friends even. We used to play silly little video games together. I would always get stuck in certain boxes and he would jump in and help me. He used to be so into Marvel and DC, and even now I think of all of these amazing things that he never got to witness, that he even said he wanted to. He wanted to see adaptations of different comics that he liked.

He was incredibly empathetic toward other people and animals. He was vegetarian for a good portion of his life. He did not like the concept of eating an animal. But even with that, for those of us who were not vegetarian, he would still make us food and assure that we were eating properly, and he was the glue that held us together.

Even when we were frustrated at each other, he would attempt at keeping peace when he could. Now we know that there is a hole missing, and nothing will ever properly fill that hole again. But that was the kind of person that he was.

Even despite his mental illness he had a story. He had a life. He had a home. He had wanted so badly to come home because we were a family, and he loved his family. Over and over again I told him, when I was younger, one of my biggest fears was losing him. He promised me, over and over, that we were family and he would not. But now rather than Vanessa and Jonathan it is just me, and I am here because of him and his legacy.

Senator OSSOFF. Ms. Fano, how old were you when all this happened?

Ms. FANO. I was still in college. It was happening during finals. That was one of the reasons I was not able to see him that last time, and I regret it because I did not think it was going to be my last chance to see him. I believe I was 19 at the time, because that was 5 years ago.

Senator OSSOFF. Ms. Fano, you mentioned that your mother did not speak English so you were translating for your family, 19 years old, throughout this ordeal. Is that right?

Ms. FANO. I was the one that had to tell her because she could not understand what he was saying, so I had to tell her that Jonathan hung himself and that he was not going to be OK. Because

she kept asking, "Is he going to get better? What did they say?" I had to explain to her that he was not, and that when we were going to get there he was not going to be well.

I had to explain when we arrived, because even then they did not have anyone on staff, or try to bring anyone on staff that could speak Spanish. Essentially through that time it was us having to translate things about his condition, about his stay, about what happened. I remember asking, "What do you mean, he hung himself for that long and they did not know? How did they not know?"

Senator OSSOFF. Thank you, Ms. Fano.

Ms. Maley, would you be willing to share a few words about Matthew?

Ms. MALEY. Of course. I was very proud of my son. He was my heart. Growing up he was rambunctious, amazed by things, involved. He was raised in the church. He participated in the church. He loved working on cars. He was involved in car shows. He liked camping and water-skiing and traveling.

Matthew was not perfect, by any means. He was a drug addict. I tried to get him help, and for that there was help, but Matthew was unwilling, for some reason. He found it easier or maybe he had mental illness that brought that on. But in saying that, we all know people that have problems, and you are there for them, unconditionally. I would have given my life for him. I begged God to take me instead of my son.

He had a lot to offer, like Vanessa's brother and Linda's son. He never met the love of his life. He never had children. There were so many things that he is never going to experience in his life. I look at my friends and I am jealous of what they have and what I could have had, and what Matthew could have had, but he made poor choices. The choices that he made, I have to live with, and it is the most difficult thing that a person can go through.

I am lost without him. I have pictures. I lost all my voicemails from him, so the shock of listening to his voice again, in the worst way possible, is just too much.

Senator OSSOFF. Ms. Maley, thank you for honoring him with your testimony today.

Professor, you study policy. You study statistics. This is not about statistics. The statistics, well collected and analyzed, can be a tool to save lives, to spare other parents and brothers and sisters this agony. I would like for you, please, to reflect on that, and share why you believe it is so essential for the Federal Government to fix this.

Ms. ARMSTRONG. I think the first part is, one of the things that we do in addition to collecting these records is we try to do something of what you all are doing here today. We memorialize the lives of people who died in the New Orleans jail, without talking necessarily about their death but for public understanding of who these people are. They were overwhelmingly Saints fans. They were poets. They were football players. They had job opportunities. It is important to recognize what we, as a community, lose, that all of us lose when people die in custody.

The other part of this that is important in terms of the Federal data collection is both of these deaths that we are talking about today happened in jails. Jails, there are over, I think, about 3,000

of them, and I have yet to see an exact list of every jail that we have in this country. They report only to themselves.

The Federal Government has unique authority to be able to collect this information from the jails in ways that members of the community cannot. Because they are so spread out, because they are all individual fiefdoms, doing their own rules, their own policies, their own practices, which may differ from facility to facility, it is the unique power of the Federal Government to be able to collect that information, and jails are where the conditions of incarceration are most hidden from our communities.

Senator OSSOFF. Is it fair to say, Professor, that, generally speaking, for each death there is more suffering, more illness perhaps poorly treated, and more folks inside in agony?

Ms. ARMSTRONG. Yes. I think the suffering that we are all experiencing today by honor the lives lost is not just the families. It is not just the people. I am also reminded that we have large numbers and members of our community who work in these facilities, who witness these traumatic incidents, because that is their employment. They too are traumatized.

Other incarcerated people often witness these deaths. They may be the ones who first report it, who sound the alarm, who bang on the steel door to alert somebody that the person next to them or in their cell is dead. That is also continuing trauma that accrues.

I would suggest that the harm to the families is enormous, but it is actually a harm that we all suffer as a community and as a society.

Senator OSSOFF. Ms. Fano, before your brother was jailed did you know anything about East Baton Rouge Parish Prison, the jail?

Ms. FANO. No. We did not know.

Senator OSSOFF. Reuters, a news organization, conducted a study of jail deaths over the last decade, and they found that from 2009 to 2019, there were 45 deaths in that facility, an average of 4.5 per year, more than double the national average. Do you think that is information that should be made public and transparent?

Ms. FANO. Yes. Absolutely.

Senator OSSOFF. Ms. Maley, the same news organization, Reuters, in the same study, found that 22 people, over the same period, died in custody at Chatham County Detention Center in our home State of Georgia, and that 50 percent of those deaths were due to illness. Now we know from your son's story that deaths due to illness can also be deaths due to illness untreated, poorly treated, or neglected. Do you believe that is the kind of information that should be made public, transparently?

Ms. MALEY. Yes.

Senator OSSOFF. Ranking Member Johnson, do you have any further questions?

Senator JOHNSON. Yes, I do, Mr. Chairman.

Professor Armstrong, you say you have 20 students and you do this. How many man hours do you put into the report you generate?

Ms. ARMSTRONG. I cannot even count them.

Senator JOHNSON. Is it over the course of a week or 2 weeks or the entire semester?

Ms. ARMSTRONG. For every fall semester I have approximately 20 students. This semester I have 23. This is a semester-long project because they file the public records request but often there is not a response under the public records law of Louisiana. They have to constantly go after these facilities—by email, by phone calls, sometimes driving there to get them.

Senator JOHNSON. We understand the process.

Ms. ARMSTRONG. Sorry.

Senator JOHNSON. Do you focus on one State, one county? What are you doing here?

Ms. ARMSTRONG. We only do it in the State of Louisiana, and we do every single detention facility in the State that we are aware of.

Senator JOHNSON. Whenever anybody dies there is a coroner report, there is a death report, there is something. Is that what you are doing your Freedom of Information Act (FOIAs) on?

Ms. ARMSTRONG. No. The jails have to report to the local coroner, but unless you know to file the public records request for that, that is difficult to get, one. Two, when we do file a public records request on coroners they often do not categorize them as in-custody deaths, so they are difficult for the coroner themselves to identify and then respond.

What we do is that we file directly with the administrator of that facility, and what we ask for is the information that they reported to the Federal Government.

Senator JOHNSON. Have you seen the 2002 to 2019 report? It has a lot of statistics to it.

Ms. ARMSTRONG. Yes.

Senator JOHNSON. What we really do need is we need those individual death reports that show what actually happened. We are talking, I think at most, was it 3,000? Senator Padilla said 5,000 deaths per year. Now, within a population of 1.5 million people, there will be deaths from natural causes and that type of thing. You are probably talking about a universe of a couple thousand deaths that you are really researching here, deaths in custody. Correct?

Ms. ARMSTRONG. That is correct. About 200 deaths per year is what we find in Louisiana.

Senator JOHNSON. In Louisiana. But I am talking about nationally now.

The reason I am asking you how many man hours you put into this, obviously I am data-driven kind of guy, being an accountant. If you have to solve problems you have to understand what the information is and how difficult it is to gather. I would not think, for the Department of Justice that has—does anybody know how many employees it has got? It is quite a few.

You could put a couple of folks doing this, and obviously we gave them resources to do this, and it would not be that difficult to literally gather the death reports on a couple thousand individuals, and if they are not getting it—they started doing this in the year 2000—they will start refining the process, and say, OK, this is not working, or we are not getting from that State. To this date we do not have—how many States did not report? We do not know which States. The Department of Justice will not tell us which States

they did not get information from. Go figure. What is that, a national security issue?

The point I am trying to make here is I think, together with all of you and the Chairman, this is important information to have. It really should not be that difficult to gather, particularly when you have been at it for 22 years. There was a break—and again, with the next panel we will analyze why this break occurred, and quite honestly, how ridiculous it is that it did occur, and why the ball was dropped here.

Mr. Chairman, I think I have gotten what I need from Professor Armstrong to move on to the next panel. But again, I want to close with my sincere condolences and my sincere thanks for sharing your tragic stories with us. It is important. We need to know these things. Thank you.

Senator OSSOFF. Thank you, Ranking Member Johnson, Ms. Fano, and Ms. Maley, on behalf of the whole Subcommittee please accept our gratitude for your presence, your courage, our condolences for your loss, and the loss that your families have suffered. We are so appreciative of the extraordinarily open and honest conversation that we have had today, as you have helped to support our efforts to bring compassion and accountability and respect for human life into public policy.

Please know that Jonathan and Matthew are having a tremendous impact here in this room today, and on behalf of the staff and the Members of the Subcommittee we will continue working to ensure that that impact is magnified through change.

Professor, thank you for sharing your expertise with us today and for your ongoing work to bring transparency and accountability to this system. It is deeply appreciated.

That will conclude the first panel and witnesses are excused with the Subcommittee's gratitude. The Subcommittee will take a brief recess as we prepare the second panel. Thank you.

[Recess.]

The Subcommittee will now call our second panel of witnesses for this afternoon's hearing. Ms. Maureen A. Henneberg serves as Deputy Assistant Attorney General for Operations and Management in the Office of Justice Programs (OJP) for the U.S. Department of Justice. Dr. Gretta L. Goodwin serves as Director of Homeland Security and Justice for the U.S. Government Accountability Office.

It is the custom of the Subcommittee to swear in all witnesses so at this time I would ask you to please stand and raise your right hands.

Do you swear that the testimony you are about to give before this Subcommittee is the truth, the whole truth, and nothing but the truth, so help you, God?

Ms. HENNEBERG. I do.

Ms. GOODWIN. I do.

Senator OSSOFF. Let the record reflect that the witnesses answered in the affirmative. You may return to your seats.

We will be using a timing system today. Your written testimonies, in their entirety, will be printed in the record. We would ask that you try to limit your oral testimony to 5 minutes.

Ms. Henneberg, we will hear from you first. Thank you.

You may proceed.

TESTIMONY OF MAUREEN A. HENNEBERG,[1] DEPUTY ASSISTANT ATTORNEY GENERAL FOR OPERATIONS AND MANAGEMENT, OFFICE OF JUSTICE PROGRAMS, U.S. DEPARTMENT OF JUSTICE

Ms. HENNEBERG. Thank you, Chairman Ossoff and thank you Ranking Member Johnson and distinguished Members of the Subcommittee. I am grateful for the opportunity to speak to you today about our work at the Department of Justice to implement the Death in Custody Reporting Act, and the ways we work with our State, local, and tribal partners to improve the conditions of incarceration. We believe that gathering data about deaths in custody is a noble and necessary step toward a transparent and legitimate justice system. There is no more solemn responsibility than the protection of life, and DCRA is designed to help us obtain information we need to assist State and Federal authorities in fulfilling this responsibility.

Since the original statute was enacted more than two decades ago, the Department of Justice, through its Office of Justice Programs, has worked hard to collect data on deaths in prisons and jails and during arrests. As I know this committee appreciates, it is a major undertaking to gather this information from 56 States and territories who, in turn, rely on reports from thousands of prisons, local jails, and law enforcement agencies. But we firmly believe that it is well worth the effort.

While the need for DCRA reporting is unquestioned by the Department, the current process deserves to re-evaluated. For many years following DCRA's enactment in 2000, our Bureau of Justice Statistics collected data called for by DCRA, which it continued to do even after the law expired 6 years later. All told, BJS has published 40 reports on the topic, which have provided a wealth of information on causes of death and characteristics of the facilities where the deaths occurred.

Then, in 2013, an update to DCRA was introduced. Signed into law the following year, the new law expanded the original DCRA. It mandated reporting by Federal law enforcement agencies. It added a study requirement focused on using the data to identify ways to reduce deaths in custody. Perhaps of greatest consequence, it gave the Attorney General the discretion to reduce funding to noncompliant States under the Edward Byrne Memorial Justice Assistance Grants (JAG) program. Through the JAG program, OJP provides over $273 million annually and funding for general purpose, law enforcement, and criminal justice activities throughout the Nation.

This last requirement posed a dilemma. As a Federal statistical agency, BJS is prohibited from using its data for any purpose other than statistics or research. Though DCRA of 2013 was well intentioned it had unintended negative consequences for the State and local collections. For one, since DCRA currently requires the Department to receive all information centrally from States, we can no longer collect data directly from State and local agencies as we once did.

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[1] The prepared statement of Ms. Henneberg appears in the Appendix on page 276.

Second, the penalty provided under DCRA of 2013 actually has the potential to punish States and local agencies that comply with the law. If, for example, local agencies decline to report to their State, that States reporting to the Department will be incomplete. Even though the State may submit all of the data it actually received, it could still suffer the funding penalty. Furthermore, since these grants pass through States to local jurisdictions, even the local agencies that fully report their information would feel the effects of a penalty applied in their State.

Finally, we can no longer assign the collection to BJS, which had achieved a nearly 100 percent response rate while it administered the program.

We are working hard to achieve more comprehensive reporting from States. We continue to provide training and assistance to States to improve reporting, and we are developing new methods for assessing State compliance and providing feedback to help improve reporting.

In the meantime, we look to Congress to help us programmatically improve the quality and completeness of data, and we have a proposal for how to do that. For instance, we are asking to collect data directly from local agencies and open sources and enable us to restrict the funding penalty to noncompliant agencies instead of applying it statewide.

We are also proposing a new grant program to help better equip agencies across the country to collect and report on deaths in custody.

The Death in Custody Reporting Act is one of the many vital tools in restoring the full integrity of our justice system. The Department provides tens of millions of dollars in resources to States, local communities, and tribes to improve the way incarcerated people are treated and to support efforts to reduce arrest-related deaths through law enforcement training and programs focused on building law enforcement and community trust. Examples of OJP's work are provided in my written testimony.

We look forward to working with all of you to meet these challenges. I thank you for your time, and I am happy to take any questions you may have.

Senator OSSOFF. Thank you, Ms. Henneberg.

Dr. Goodwin, you are now recognized for your opening statement.

TESTIMONY OF GRETTA L. GOODWIN,[1] PH.D., DIRECTOR OF HOMELAND SECURITY AND JUSTICE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. GOODWIN. Chair Ossoff and Ranking Member Johnson, I appreciate the opportunity to discuss the actions DOJ has taken to address the data collection and reporting requirements in the Death in Custody Reporting Act of 2013, and the extent to which DOJ has studied and used the data collected from States.

As already discussed, DCRA was enacted in 2014 to encourage the study and reporting of deaths in custody. Federal agencies and States that receive certain Federal funding are required to report this information to DOJ. DOJ is to study the Federal and State

[1] The prepared statement of Ms. Goodwin appears in the Appendix on page 289.

data, examine how the information can be used to reduce deaths in custody, and report its findings to the Congress.

In 2015, DOJ began collecting data on the deaths of people in the custody of Federal law enforcement. As of fiscal year 2020, DOJ reported 2,700 deaths in Federal custody. While the agency collects the same information at the State and local level, it has not actually reported on these deaths.

DOJ began collecting information from States on death in custody about 3 years ago. Agency officials told us they plan to continue collecting State data, but they have not said whether or how they will use the information to address deaths in custody.

DOJ cites missing and/or incomplete data from States as one of the reasons why they have not studied the State information. We found similar concerns when we examined the data. For example, of the 47 States that submitted data, only 2 submitted all the required information. Some States did not account for all deaths in custody.

Using publicly available reports, we identified nearly 1,000 deaths that occurred during fiscal year 2021, that States did not report to DOJ. Four States did not report any deaths, yet we found that at least 124 deaths had occurred in those States.

DOJ has noted that it is a top priority to improve the quality and completeness of State reporting. In 2016, the agency acknowledged that determining State compliance with DCRA would help improve the quality of the data, and they have a goal to help ensure States comply with DCRA. However, as of this month, September 2022, DOJ still has not determined whether States have complied. While DOJ collects data from States, DCRA does not require DOJ to publish State data, and the agency has no plans to do so.

Importantly, after DOJ's DCRA data collection efforts began, it discontinued a longstanding program that collected and published data on deaths of people in State and local correctional institutions, the Mortality in Correctional Institutions program. DOJ had used these data to publish reports and provide statistical information on deaths in correctional institutions. This published information allowed Congress, researchers, and the public to view and study the data.

While the Mortality in Correctional Institutions report was made publicly available, the DCRA report may not be available to the public. This lack of transparency would be a great loss in the public's understanding of deaths in custody.

Given that 1.5 million people were incarcerated in State prisons and local jails at the end of 2020, statistics on deaths in custody are a valuable resource for understanding mortality in the criminal justice system. DOJ has made some progress toward addressing what it calls a profoundly important issue, but significant work remains because right now DOJ and States are expending resources to compile a national dataset that may not be studied or published, potentially missing an opportunity to inform practices to help reduce deaths in custody.

We are encouraging Congress to consider whether DCRA should be amended to ensure that DOJ uses the data it collects from States for recurring study and reporting to Congress and the public, and to help enhance the quality of the data, we are recom-

mending that DOJ develop a plan to determine State compliance with DCRA.

Chair Ossoff and Ranking Member Johnson, this concludes my remarks. I am happy to answer any questions you have.

Senator OSSOFF. Thank you, Dr. Goodwin and Ms. Henneberg, for your opening remarks and for your presence here today.

I want to begin, Dr. Goodwin, by making sure that it is clear what you found. I think in some ways the most powerful and alarming piece of data that you and your team unearthed at the request of the Subcommittee is that in 2021, you found nearly 1,000 deaths in State or local facilities that the Department did not capture. You found them through a review of open sources. Is that correct?

Ms. GOODWIN. That is correct, Senator. The way that 1,000 deaths kind of breaks out—and actually it is 990, but we say nearly 1,000—so the way that breaks out is 341 of those deaths that we discovered were in State correctional facilities. How did we get there? We basically used publicly available data. Some States, when they are doing their annual statistical reporting, they provide that information. We went through and did as thorough of an analysis as we could to get to the 341.

Then the remaining deaths, the 649 deaths, again we used publicly available data and we used a couple of databases that collect information on deaths that happen when someone is placed under arrest or when a death happens in custody. That is how we arrived at the nearly 1,000 deaths. But for the most part a lot of this was publicly available data.

One more thing I forgot to add. For the 341 deaths, it was publicly available data, and we had access to some of the DCRA records, and we went through and tried to do some matching.

Senator OSSOFF. Thank you, Dr. Goodwin. Nearly 1,000 deaths uncounted last year alone.

Ms. Henneberg, I do want to first of all point out, this is not a political or a partisan issue. The cascade, the debacle, the decline in the Department's ability to collect and produce high-integrity data has unfolded over several years and multiple administrations. This is not a partisan issue. We appreciate your presence here today to help us sort through these issues.

You have been working at the Office of Justice Programs for 20 years and leading operations in management for the past 7. Correct?

Ms. HENNEBERG. I have been at the Office of Justice Programs for 32 years. I have been part of the leadership team since February 2014 as the Deputy Assistant Attorney General for Operations and Management, overseeing our business offices.

Senator OSSOFF. Thank you, Ms. Henneberg. Your office is responsible for the implementation of DCRA. Correct?

Ms. HENNEBERG. The Office of Justice Programs, our Bureau of Justice Assistance at this time is overseeing the reporting from the States. That is correct.

Senator OSSOFF. Yes. Thank you, Ms. Henneberg.

As we have discussed, 1.5 million people are incarcerated in State prisons or local jails. Thousands die every year. Why is it im-

portant, in brief please, for the Department to study and report on deaths in custody?

Ms. HENNEBERG. The Department shares your goals, Chairman Ossoff, to improve the data that is being reported, the accuracy, the quality, the completeness of the data. This data is extremely important. It is critical to understanding deaths in custody, understanding the relationship between the deaths in custody and the policies and practices of State jail, law enforcement agencies.

Senator OSSOFF. I agree, Ms. Henneberg. Here are some quotes from bipartisan Members of Congress, Representatives and Senators, about the purpose of DCRA.

It would bring "a new level of accountability to our nation's correctional institutions." It would "provide openness in government." It would "bolster public confidence and trust in our judicial system." It would "bring additional transparency."

Do you agree that these are among the purposes of this data collection?

Ms. HENNEBERG. The Department agrees that there is a critical value in all of these data to collect the data from the States, to analyze the data, to present findings so that we can better understand deaths in custody, so we can determine whether there are strategies to reduce deaths in custody.

Senator OSSOFF. Thank you, Ms. Henneberg.

The Bureau of Justice Assistance, a component agency within the Office of Justice Programs—and those who are tuned in across the country will have to indulge and tolerate some acronym chaos here—but the Bureau of Justice Assistance started collecting State and local death data in 2019. The Bureau of Justice Statistics, which had previously collected this data, in fact for two decades collected this data, with success, analyzed the data that the Bureau of Justice Assistance collected, in 2020, and produced a report in May 2021.

It identified some significant issues that BJA did not capture any State or prison deaths in 11 States, or any jail deaths in 12 States and the District of Columbia. That from October to December 2019, BJA missed at least 592 deaths.

Were these results concerning to the Department of Justice?

Ms. HENNEBERG. The Department of Justice, over the 2, 3 years that we have been collecting the data, we have seen the underreporting from States. Under DCRA 2013, States are having to collect data from their local agencies, and they are centrally reporting to BJA. The States are reporting great challenges. I think GAO's report will show this, and we have heard the same thing from our States. The States have no leverage to compel their local agencies to report the data.

Senator OSSOFF. Thank you, Ms. Henneberg. I appreciate your perspective on that State-local issue. My question is a specific one, if you will please. When BJS, your statistical office, having reviewed the first quarter of collection undertaken by BJA, reported to the Office of Management and Budget (OMB) and to the Department that BJA had missed State prison deaths in 11 States, jail deaths in 12 States, that from October to December of that first period when BJA was undertaking this collection, that it missed 592 deaths, was that concerning? Surely that was concerning. You were

transitioning from one agency to another. The prior agency was telling you it is not working. Was that concerning?

Ms. HENNEBERG. It is very concerning that there is the underreporting, and it is widespread across all the States. It is not just in certain areas.

Senator OSSOFF. OK. Thank you, Ms. Henneberg. It was concerning. In response to those findings by BJS, what did the Department of Justice do to repair and improve its data collection methodology so those problems would not persist?

Ms. HENNEBERG. The current Administration, the current Department, we are focusing on fixing the problems and the obstacles that we have observed with the reporting under DCRA 2013. We are presenting legislative proposals to amend DCRA so that we can address issues that we believe are contributing to the underreporting. Having States serve as the central repository and the central reporter is certainly contributing to——

Senator OSSOFF. Ms. Henneberg, you will have to forgive me, but we are trying to understand, with precision, what unfolded within the Department that led to a significant decline in the integrity of the data that the Department was collecting. I am looking for a precise answer to a very particular question.

In the first few months when BJA took this over from BJS, BJS continued collecting and then they compared datasets. BJS, your statisticians, your folks who specialize in this, they raised a big red flag. They said what BJA is doing is not working.

My question is, in response to that specific information, that warning, what action was taken to improve BJA's methodology? Not generally, not broadly, not legislative fixes that are being sought now. What action was taken then?

Ms. HENNEBERG. Thank you for the question. I think it is important to describe when BJS was collecting the data they were able to go directly to local agencies, local correctional institutions, jails, and collect that data. Under DCRA 2013, BJA was presented with working with the States' central reporters, which is a significant contributor to the underreporting and the incomplete data.

BJA has worked with a training and Training and Technical Assistance (TTA) provider, providing direct technical assistance to the States to review their data that is coming in, identifying ways they can improve it. We have provided trainings to the States. We have provided one-on-one technical assistance with the States to help them think through their data collection strategies, to identify areas where there is underreporting so that we can——

Senator OSSOFF. Ms. Henneberg, we do not have unlimited time here and I am not getting a precise answer to that question. I will have to circle back.

I am going to yield now to Ranking Member Johnson and I will return for a second round in a moment. Thank you.

Senator JOHNSON. Thank you, Mr. Chairman. Ms. Henneberg, can you bring your microphone a little bit closer to your mouth?

I want to know how many people are working on this within the Department of Justice.

Ms. HENNEBERG. Our Bureau of Justice Assistance is a grant-making agency so their primary function is grant-making.

Senator JOHNSON. How many people are working on providing this data? How many people? Is it 10? Is it 3 dozen? How many people?

Ms. HENNEBERG. I do not know the answer. I will go back and we can look at how many people are working on——

Senator JOHNSON. I want to know how many people were working in the Bureau of Justice Statistics and then I want to know how many people in the Bureau of Justice Assistance, OK? I want to know how many people.

Ms. Goodwin, when you say you got publicly available records, what are you talking about there? Are you talking death certificates? Are you talking about reports that States and local governments publish and you were able to tap into those things?

Ms. GOODWIN. I will say, Senator, it is a little bit of both. For some States, when they report their deaths, that information shows up in like an end-of-year annual statistical supplement. We basically did a Google search to see what we could find.

Senator JOHNSON. How many people did you have at GAO take a look at this?

Ms. GOODWIN. Two.

Senator JOHNSON. You had two people, over what length of time?

Ms. GOODWIN. From May to September, May 2022 to September 2022.

Senator JOHNSON. OK. What is that, about 5 months?

Ms. GOODWIN. Yes.

Senator JOHNSON. You had two people, and with two people working for a few months you determined that we were missing close to 1,000 death reports, because you were able to find them just with open-source reporting, basically.

Ms. GOODWIN. That is correct. A lot of it was open-source reporting. A lot of it, publicly available data. Some of the databases that do collect this information, the non-DOJ databases that would collect it.

Senator JOHNSON. Do either of you know approximately how many deaths occur in custody within State and local jails every year?

Ms. GOODWIN. Unfortunately, we do not, and that is——

Senator JOHNSON. I mean, just ballpark. I am not talking precise right now. I am talking ballpark. Is it a couple thousand?

Ms. HENNEBERG. BJS says in 2019, in local jails there were 1,200 deaths.

Senator JOHNSON. I got that local. What about State?

Ms. HENNEBERG. State and Federal was about 4,200.

Senator JOHNSON. Why do you combine State and Federal and not State and local? It is not a trick question. It is a question. It is a curiosity. Because we normally separate Federal, and then you have State and local. You did it the other way. Why?

Ms. HENNEBERG. Local jails is a different type of facility than Federal and State prison.

Senator JOHNSON. But is not State prison different than Federal prison?

Ms. HENNEBERG. Correct.

Senator JOHNSON. OK. You have probably a couple thousand, 2,000 to 3,000 prisoners dying in custody in State and local prisons.

The interesting thing, as I was going through here, I assumed this was going to be State and local, but it kept saying local, and it is only local. Why did you issue this report chock full of information, by the way, statistics, on only local? Why did you not combine it with State?

Ms. HENNEBERG. I am sorry, Senator Johnson. What report are you referring to?

Senator JOHNSON. The whole purpose of DCRA is to determine the deaths in custody in State and local jails. Correct?

Ms. HENNEBERG. Correct.

Senator JOHNSON. When you publish a paper on deaths, mortality, 2000 to 2019, why did you only do local? Why did you not do State and local, because that was the whole purpose of DCRA?

Ms. HENNEBERG. In 2019, BJS did publish State and Federal deaths.

Senator JOHNSON. OK. Weird combination.

I think my point here is that we are talking about a pretty manageable amount of information. With a little bit of dedication from the bureaucracy, now I have it, of 117,000 people in the Department of Justice, a bill that was passed in 2000 and reauthorized in 2013—so obviously you realized Congress wanted this information—you were collecting some of it and then you kind of stopped.

I heard the explanation that when Congress passed the reauthorization they tied it to funding and there is a penalty there so all of a sudden the Bureau of Justice Statistics could no longer handle that. That is bureaucratic impediments. I have got that.

But it would not seem like it would be that much of a heavy lift. We will find out. I really do want to know how many people in BJS were working on providing this information, and then how many people in BJA were charged with that.

You would have thought in a meeting or two you could have combined your efforts and said, "This is what we did, and you ought to do the same thing," which is the question the Chairman is trying to get at. Where was the breakdown here?

I will ask you, where was the breakdown? Because it seems like BJS was able to collect this information, and all of a sudden, for whatever bureaucratic impediment, they had to turn that over to BJA. What was so hard about a pretty smooth handoff?

Ms. HENNEBERG. This department is focused on fixing and improving the data collection, so we are focused on how we can——

Senator JOHNSON. You have been focusing on it how many years? You have utterly failed. Literally, you have utterly failed. This is not that hard. GAO, two people, over a few months, got us better statistics than the Department of Justice did for how many years? We do not even know what States were not reporting, the 11 and 12. You were not even able to answer that question from staff.

What is the impediment to getting information from States? You have 50 States. You get a couple of people. Put them on it full-time. They start talking to these States. You go, this information is missing. Over the course of 22 years I would have thought this information-gathering process would have been pretty well honed and these reports would have been automatic. You probably could have put one person on it, part-time.

What is wrong with bureaucracies? Why can they not accomplish the simplest of tasks, and why will you not be transparent and honest with why you are not able to do it? I am not asking for answers to these things, just rhetorical questions, but do you have any response?

Ms. HENNEBERG. Senator Johnson, I do. The response that I gave in my oral statement and that I have tried to reiterate here is that DCRA 2013 provides for a different reporting structure. That reporting structure has left the States with little to no leverage or incentive to get the information from local agencies and law enforcement agencies. We are working with——

Senator JOHNSON. Did they not actually increase the incentives? Did they not attach funding to it, and there is a penalty of not receiving funding if they did not, I did not think they had incentives in 2000. I think that was part of the issue with reauthorization, was it not, they actually put penalties to it? But it seems like they were far more successful with the prior law.

Ms. HENNEBERG. The JAG penalties that are currently in DCRA 2013 have unintended consequences. If a State is reporting everything that they are receiving from local agencies, and it is incomplete, they would potentially be found in noncompliance and their State funding would be cut, even though they would be working in good faith with——

Senator JOHNSON. I will say it does not surprise me that Congress might have screwed something up here, and we maybe should take a look at that. But we need to fully understand it first, exactly what happened. How are we collecting it under BJS? How are we collecting it under BJA? We need transparency. We need some help. This should not be so difficult to get this answer. This should not be so difficult to fix, to start getting the death reports. Quite honestly, I would want more information. I want the stories.

By the way, were you listening to our witnesses on the first panel?

Ms. HENNEBERG. I was not able to join the hearing but I did look at the victim list, and those are very heartbreaking stories.

Senator JOHNSON. What I would suggest you do is you go back to the Department of Justice and you have anybody involved in this process get a clip of the testimony. I think that might incentivize you to get on this case and get this information. OK?

Ms. HENNEBERG. Senator, we are proposing fixes, legislative changes to DCRA 2013 so that the Department can be in a better position and have the ability to——

Senator JOHNSON. I come from the private sector. I would have this fixed in about 10 minutes. That it has taken you years is beyond comprehension, quite honestly. But we are going to have to do it the government way, but we ought to get to the bottom of this.

Senator OSSOFF. Thank you, Ranking Member Johnson. Dr. Goodwin, why is it important to have a full and accurate accounting of death in custody data?

Ms. GOODWIN. Senator, I will harken back to the previous panel where you asked them, and I would like to add onto the conversation when we think about collecting these types of statistics there are people at the end of these statistics. They are not just numbers.

We are talking about people, and we are talking about people and their families.

Collecting this information is useful to policymakers. First, it is useful to DOJ to help them better understand what is happening that might be causing these deaths, what modifications might need to be made, what changes might need to be made, is there training, what needs to happen in the correctional institutions to ensure that there are not any deaths?

Then once that happens, informing the policymakers, what needs to happen? If there needs to be a change in policy, what needs to happen to ensure that these deaths do not keep occurring?

Senator OSSOFF. Thank you, Dr. Goodwin, and according to your analysis of DOJ's data from last year, we already discussed nearly 1,000 deaths that your team was able to identify through open sources uncounted in the DOJ data. Is it also the case that 70 percent of the death in custody records produced by States to the Department were incomplete, and 40 percent of those records did not even include a description of the circumstances of death. Is that correct?

Ms. GOODWIN. That is correct, Senator. Under DCRA there are certain types of information that are supposed to be reported. One, the race, ethnicity, gender of the individual who is deceased, the location of the death that happen, what was occurring during that time. There are a number of different elements, shall we say, that should be reported under DCRA when they are making reports about what happened.

When we looked at the data, as you said, 70 percent had X amount, 40 percent had X amount. That was a concern as well.

I would also like to add, Senator, that our nearly 1,000 deaths that we found, we believe that is an undercount. We were doing a very quick but thorough analysis based on what was available to us, but we are mindful that some of that information might not have been reported anywhere or might have been misreported. We do believe that is an undercount. It is another reason why we are calling on DOJ to do what they can to ensure State compliance with DCRA, so that we can have a more accurate picture of what is happening in these correctional institutions.

Senator OSSOFF. Let us crystallize those findings, and I am so grateful to you and your staff for undertaking that analysis at our request, for supporting this investigation, for your professionalism, and for your hard work. I want to condense this down to the key facts I think the public needs to hear.

You found nearly 1,000 deaths last year alone uncounted by DOJ, and you believe it is likely a significant undercount. Seventy percent of the records they did collect were incomplete, and 40 percent of the records did not even include a description of the circumstances of death.

Ms. GOODWIN. That is correct.

Senator OSSOFF. The professor on Panel 1, Professor Armstrong, discussed how we cannot effectively intervene to remedy facility-level abuses, misconduct, poor conditions, poor health units, the kinds of things that lead to higher rates of death in those facilities, unless we know where the problems are. Do you agree with that, Dr. Goodwin?

Ms. GOODWIN. Yes, we do.

Senator OSSOFF. Do you agree that if we do not understand, in 40 percent of the records collected—again, putting aside nearly 1,000 records that were not collected at all, and perhaps many more—putting that aside, when 40 percent of the records do not even include a description of the circumstances of death, that the purpose of this collection to yield insight for policymakers so that we can intervene and save lives, is undermined?

Ms. GOODWIN. Yes. DCRA was put in place, DCRA was enacted, to deal with and minimize deaths in custody. Part of that data collection, once you have the data you have some idea of what might need to be done. I will also add that some States might be doing some really good things within their States. We just do not know because that data is not being collected.

I would also like to add that even if the data were collected, what we found in our conversations with DOJ, they do not have any plans to publish the data. The data would be collected and what would be done with it is really the question.

Senator OSSOFF. That is a good segue, Dr. Goodwin. Let me ask you, Ms. Henneberg, please, about that. Why has DOJ ceased to publish this data after nearly 20 years of making this information public? Is there not an obvious and vital public interest in transparency here?

Ms. HENNEBERG. Thank you for that question, Chairman Ossoff. DCRA 2013 provides that the States report the data and the Department will use that data to analyze data and study the data to determine what strategies we can use to reduce deaths as well as the relationship between policies, procedures, management actions relating to these deaths.

Yes, the Department strongly agrees with GAO that we must strengthen how we collect data under DCRA, and I think our legislative proposal is aimed at fixing this.

Senator OSSOFF. Ms. Henneberg, I appreciate that. But my question is why DOJ ceased the publication of this data when it fulfills such a vital public interest?

Ms. HENNEBERG. Thank you for the question. I think it is important to talk about that, from two perspectives, one a legal perspective as well as a data perspective. From the data perspective, the data, as we hear and as we agree with GAO and hearing from the States, there is significant underreporting, and providing that data would be misleading. It would not provide a full picture of what is happening with deaths in custody.

Senator OSSOFF. Ms. Henneberg, I am going to let you complete that answer, but I want to make sure I hear and understand what you are saying and in public hears and understand what you are saying. You are saying that you have ceased to publish that data because you no longer have complete and accurate data. Correct?

Ms. HENNEBERG. The Department is working with the States, who are the central reporters of that data, to collect that data. The States are to collect that data from local agencies and local law enforcement. The States are challenged collecting that data, and we are working with the States through technical assistance. We are looking at open sources to identify those deaths that the States are

not reporting, going back to the States and working with them to improve their data collection.

Senator OSSOFF. Ms. Henneberg, DOJ has ceased the publication of this data because the data is no longer of sufficient completeness, accuracy, and integrity to publish it. That is the first reason. You were going to give a second reason why you have ceased publication of the data.

Ms. HENNEBERG. The second reason would be the data under DCRA 2013 is being collected to be analyzed and studied, and we are currently doing that. The National Institute of Justice is undertaking a multiyear effort to review the data as well as looking at other sources of data to be able to provide findings on relationships between deaths in custody, policies, practices of institutions.

Senator OSSOFF. Let us discuss that report, Ms. Henneberg. I understand what you are telling us is this data, which was published for 20 years, is no longer being published because of concerns about now the accuracy of the collection of the data, the completeness of the collection of the data.

You mentioned, though, the broader report mandated by Congress in DCRA 2013. Correct?

Ms. HENNEBERG. DCRA 2013 provides that the data is analyzed and studied. Correct.

Senator OSSOFF. That is right. DCRA required the Department of Justice to issue that report to Congress. I want to pivot for a moment to Dr. Goodwin and get her perspective on why this report is so important. This was a mandate that Congress gave to the Department to take the data that is being collected and then investigate it for insights that could yield solutions to reduce the incidence of death in custody. Correct, Dr. Goodwin?

Ms. GOODWIN. That is correct, and when we last spoke with DOJ in August 2022, they told us that they had not yet studied the data to determine how that information could be used to reduce deaths in custody. But it sounds like that is happening now.

Senator OSSOFF. OK. Thank you, Dr. Goodwin.

Ms. Henneberg, the law required that report to be issued to Congress no later than December 2016. The Department has not yet issued that report. Correct?

Ms. HENNEBERG. Correct. The Department——

Senator OSSOFF. We are now almost 6 years past the deadline. Right?

Ms. HENNEBERG. The Department values that data, and we are studying it, and we are very eager to get the findings so that we can better understand deaths in custody and reduce deaths in custody that can be prevented.

Senator OSSOFF. Ms. Henneberg, the regular publication of this data, that BJS was previously collecting, has stopped because now, with BJA collecting, the data is not good enough to publish. We have established that.

But this failure to report to Congress predates that transition. Back in 2016, when this report was due, BJS was still running the collection and still running the analysis. There is no excuse here that the data is not good enough, because BJS was doing a pretty good job, by most accounts, of collecting that data. Why is this report now 6 years late, and am I correct that the Department did

not even award a contract to a contractor to produce this report until September 2021? Is that correct?

Ms. HENNEBERG. That is correct for one piece of the study. Correct.

Senator OSSOFF. The Department did not award a contract to produce this study, and again, we are talking about studies and contracts and mandates. Let us bring this back to human beings. We are talking about a study whose purpose is to look at data about people dying in prisons and jails, and give policymakers at the Department of Justice and the Congress the insight and wisdom based on that data to prevent those deaths, to fulfill an urgent humanitarian purpose. That is why Congress gave that mandate to the Department.

What you are telling me is that not only is the report now 6 years late, but the Department did not retain a contractor to produce that report until 5 years after it was due. Why?

Ms. HENNEBERG. Senator, thank you for that question, and it is a good question. BJA began collecting the data in fiscal year 2020, so October 2019, and data needed to be collected to study. That is what DCRA 2013 is calling for, collect the data and then study the data so that we can understand the deaths.

Senator OSSOFF. But it was due in 2016.

How about, let us be forward-looking here. Can you give us a date certain when Congress will receive this report that is now 6 years overdue?

Ms. HENNEBERG. There are two parts of that study. One we do have a draft, the first part, and it is discussed in our report that we put out last week, that will be available, we are estimating, by the end of calendar year 2022. The other is a multiyear effort by National Institute of Justice (NIJ) that is not only using the data that is being collected under DCRA 2013, but also other sources. The data elements and the data being collected under DCRA 2013 is not sufficient to meet the purposes of the study and the scope of the study, so we are expecting that in 2024.

Senator OSSOFF. Eight years late. Thank you, Ms. Henneberg.

Ms. Henneberg, as I mentioned in my opening remarks, and I am grateful for your testimony here today, I am here to work with the Department to get this right because ultimately getting this right is what matters because lives are on the line. This is not about shuffling paper and having these kinds of exchanges in rooms here in the Senate.

This is about the Americans who are locked up, many of them pretrial detainees who have been convicted of no crime, who are dying every year, in many cases preventably, who are not being counted, whose causes of death are no longer being collected, and whose locations of death are no longer being collected. The fact that we do not get the information that we have tasked you with producing, and the insight and analysis that we have tasked you with producing, until 6 or 8 years after a deadline, that has cost human lives. That is why this matters.

I am surely here to work with you and your colleagues. If legislation is what is required, let us legislate. But I am sure you can understand, Ms. Henneberg, and your colleagues can understand, that for the Department to come 8 years after a law is enacted and

say you have determined that you cannot implement it successfully, 8 years have now gone by where people have been dying.

I know from my brief time here that when Executive Branch agencies decide they really need something, they make us aware, immediately, of what they really need. Eight years have gone by since this law was enacted, and now we are hearing that you cannot carry out your mission, that you cannot collect accurate and complete data, that you cannot publish the data you are collecting because it is not accurate and complete, that you cannot produce for us the 6-years-late report on what you have learned about saving lives in prisons and jails, because at least, in part, the data is not complete.

I have to note, in 2018, the Office of the Inspector General warned that the methodology DOJ was undertaking was likely to fail. Here is what the Office of the Inspector General said: "Without complete information about deaths in custody the Department will be unable to achieve DCRA's primary purpose, to examine how DCRA data can be used to help reduce the number of deaths in custody."

This is 2018, the Office of the Inspector General, your internal watchdog, also wrote, "We found the Department does not have plans to submit a required report that details results of the study on DCRA data." Four years ago, the Office of the Inspector General warned that the methodology is not going to work, warned that report is not going to be produced.

The inspector general also said what Dr. Goodwin has said today, "We believe that not releasing DCRA data and analysis limits the utility of the data collection effort and the Department's ability to use the data to increase public transparency about deaths in custody and take steps to reduce their number." Then again in 2021, your statisticians, the Bureau of Justice Statistics, are warning that the methodology is going to fail. We have all those documents. But it was not fixed.

Now 8 years after the law was passed, you are telling us you need legislation. All the while people have been dying. Where is the urgency?

Ms. HENNEBERG. Chairman Ossoff, I can assure that the Department understands the value of this data, that we understand the critical nature of having the data to know more about deaths in custody. We value the purposes of DCRA 2013 and previous DCRA 2000 and what it is intended to do. We are faced with a statute that provided that the States collect the data, and we were following that approach, States directly being the central reporters.

We have now proposed legislative fixes. The Department is committed to fixing this. This current administration, this Department is focusing on fixing what we have observed the last couple of years with DCRA reporting.

Senator OSSOFF. I appreciate that, Ms. Henneberg, and I do want to note that President Biden issued an Executive Order (EO) on May 25th, calling for the Department to release its plan for full implementation and compliance with DCRA. That was noted. We have received some of the preliminary information.

We have to get this right. We are going to wrap up this hearing in just a moment, but we have to get this right.

Dr. Goodwin, I am so grateful to you for the analysis and investigation that you undertook in response to our Subcommittee's inquiry. Ms. Henneberg, I appreciate your testimony today. There is no doubt that this has been poorly managed within the Department of Justice, that as a result the Congress and the Department have been unable to take steps that could have saved lives.

But as I said, I am here to work with you to fix this as soon as possible because it must be fixed.

I will close with this, and this brings us back to the experiences of the Americans we heard from in the first panel. Jonathan Fano, Matthew Loflin, two Americans who were sitting in jail, pretrial detainees convicted of no crime, who died in the custody of their own government, who died preventably in the custody of their own government. There are thousands more, and tens or hundreds of thousands of family members who have experienced what our two witnesses today experienced.

There is an ongoing humanitarian crisis in America's prisons and jails. People are dying every week in America's prisons and jails, many of them preventably.

Ms. Henneberg, I hope you leave this hearing fully committed to tasking your entire team with the urgency warranted by a crisis that is taking lives. Dr. Goodwin, I thank you for supporting our efforts to bring transparency to this important issue.

With that this hearing is adjourned.

[Whereupon, at 4:59 p.m., the Subcommittee was adjourned.]

APPENDIX

Opening Statement of Chair Jon Ossoff
"Uncounted Deaths in America's Prisons and Jails: How the Department of Justice Failed to Implement the Death in Custody Reporting Act"
U.S. Senate Permanent Subcommittee on Investigations
Homeland Security and Governmental Affairs Committee
September 20, 2022

The Permanent Subcommittee on Investigations will come to order.

Today, the Subcommittee continues our bipartisan work investigating conditions in prisons, jails, and detention centers across the United States. I thank the Ranking Member for his cooperation.

In July, we released findings of corruption, abuse, and misconduct in the federal prison system, and questioned the now-former Director of the Federal Bureau of Prisons.

Today, after a 10-month bipartisan investigation, we can reveal that despite a clear charge from Congress to determine who is dying in prisons and jails across the country, where they are dying, and why they are dying, the Department of Justice is failing to do so. This failure undermines efforts to address the urgent humanitarian crisis ongoing behind bars across the country.

Our investigation has revealed that last year alone, according to GAO analysis that I requested, the Department of Justice failed to identify at least 990 deaths in custody. Nearly one thousand uncounted deaths, and the true number is likely much higher.

We will hear today from Belinda Maley and Vanessa Fano, whose loved ones died preventably while in custody — in both cases, sons and brothers who died while they were pretrial detainees, having been convicted of no crime. We will hear their grief and anger, a grief and anger shared by many thousands of Americans whose loved ones needlessly suffered and died while incarcerated.

We will hear from Professor Andrea Armstrong of Loyola University to understand why and how DOJ's failure to oversee prisons and jails undermines Americans' civil rights.

We will hear from Dr. Gretta Goodwin of the Government Accountability Office, a legislative branch agency that provides investigative services to Congress, which analyzed at my request the death in custody data that DOJ collected in 2021, and who will publicly report those findings today for the first time.

And we will question Ms. Maureen Henneberg, Deputy Assistant Attorney General, about the Department's failure since 2019 to implement the Death in Custody Reporting Act — a failure that has undermined Federal oversight of conditions in prisons and jails nationwide, and therefore, undermined Americans' human and Constitutional rights.

Members of Congress swear to 'support and defend the Constitution of the United States' — to defend the Constitutional rights of all Americans, in my state and every state, including the rights of those who are incarcerated.

We are here today because what the United States is allowing to happen on our watch in prisons, jails, and detention centers nationwide is a moral disgrace.

As federal legislators serving on the nation's pre-eminent investigative panel, it is our obligation to investigate the federal government's complicity in this disgrace.

Therefore, it's our obligation to ask, what tools the Department of Justice is using to protect the Constitutional rights of the incarcerated — to hold DOJ accountable when it fails to use those tools — and to furnish better, more powerful tools with which the Department can defend civil rights and civil liberties.

There are some bright spots. For example, I was encouraged when Assistant Attorney General Kristen Clarke announced a DOJ investigation of conditions in Georgia's horrific state prisons almost one year ago today.

But it has become clear in the course of this investigation that the Department is failing in its responsibility to implement the Death in Custody Reporting Act — that is, the Department is failing to determine who is dying behind bars, where they are dying, and why they are dying — and therefore failing to determine where and which interventions are most urgently needed to save lives.

In 2000, and then again in 2014, Congress passed the Death in Custody Reporting Act, also known as DCRA, tasking DOJ with the collection and analysis of custodial death data nationwide.

DOJ itself describes this law as, quote, 'an opportunity to improve understanding of why deaths occur in custody and develop solutions to prevent avoidable deaths.'

For nearly twenty years, DOJ collected and published this data — an invaluable resource for the Department, for the Congress, and for the public.

Then, abruptly, that publication stopped, and our investigation followed.

We found that in recent years, and over multiple Administrations, the Department's implementation of this law has failed, despite clear internal warnings from DOJ's own Inspector General and DOJ's Bureau of Justice Statistics.

For example:

- In the first quarter of FY 20, the Department of Justice did not capture any state prison deaths in 11 states or any jail deaths in 12 states and the District of Columbia.

- In FY 21 alone, according to GAO analysis produced at our request, the Department failed identify nearly 1,000 deaths, and my assessment is the true number is likely much higher. Of those records that were collected, 70% were incomplete, and 40% of records failed to capture the circumstances of death.

The Department of Justice has:

- Failed to collect complete or accurate state and local death data for the past two years; and

- Failed to report to Congress how data about deaths in custody can be used to save lives — a report required by law that is now six years past due and, and we recently learned, is not expected to be produced for another two years.

- PSI's investigation also found that the Department has no plans to make state and local death data public again — despite the obvious public interest in this transparency.

Now today's hearing may dive at times into arcane discussions of administrative regulations or the close parsing of legislative text.

And those discussions are relevant. They are relevant.

If the Department has concluded in 2022, eight years after this law was reauthorized, that it is incapable of successfully implementing it, I am surely willing to work with them to help fix that.

But this hearing is about something more fundamental.

Americans are needlessly dying, and are being killed, while in the custody of their own government.

In our July hearing focused on the federal prison system, we revealed that federal pretrial detainees have been denied proper nutrition, hygiene, and medical care; endured months of lockdowns with limited or no access to the outdoors or basic services; and had rats and roaches infested their cells.

We revealed that federal inmates killed themselves while the basic practices of suicide prevention and wellness checks were neglected — abusive and unconstitutional practices by the Federal government that likely led to loss of life in federal facilities.

We revealed that the Bureau of Prisons, an agency of the Department of Justice, was warned for years by its own investigators of corruption and misconduct in its own facility, of a 'lack of regard for human life' by its own personnel.

Today, we will hear about the experiences of Americans in state and local prisons and jails, Americans entitled to Constitutional rights no matter whether they are incarcerated—no matter whether they are incarcerated. And we'll hear about Americans who died in custody, many of whose deaths and causes of death are not being counted by the federal government— As the federal government is bound to count them. The same federal government obligated to defend their constitutional rights

Before I yield to the Ranking Member, and with Ms. Maley's permission, I'm going to share an audio clip of the last phone call that she shared with her son while he was jailed — a pretrial detainee who was never convicted of any crime.

I want to want those who are tuned in across the country that this is a disturbing clip. And while this audio plays, ask how we might feel on either end of this call. Please play the audio.

[AUDIO PLAYS]:

Mother: Matthew?

Loflin: Hey.

Mother: Okay, listen I found out everything I can. I'm gonna try to get… um, I'm having lawyers and the sheriff and all this other kind of shit trying to make it so I can come in there and see you. I am trying also to get you out of there and get you . . .

Loflin: I need to go to the hospital.

Mother: I know…

Loflin: I'm gonna die in here.

Mother: I know you are Matthew. I am doing everything I can to get you out, and so I can see you. Hello?

Loflin: Yeah.

Maley: They're doing everything they can.

PHONE: There are 15 seconds remaining.

Loflin: I've been coughing up blood and my feet are swollen. It hurts, Mom.

Mother: I know Matthew, I know what is wrong with you. I told you this would happen. I love you, Matthew. They are going to cut us off…

Loflin: I love you too. I'm gonna die in here...

The crisis in America's prisons, jails, and detention centers is ongoing and unconscionable. The Department of Justice and the Congress must treat this as the emergency to Constitutional rights that it is.

Senator Johnson, I yield to you.

Opening Statement of Ranking Member Ron Johnson
"Uncounted Deaths in America's Prisons and Jails: How the Department of Justice Failed to Implement the Death in Custody Reporting Act."
September 20, 2022

As submitted to the record:

This hearing is a continuation of the Permanent Subcommittee on Investigations' ("PSI") important oversight of the Department of Justice ("DOJ"). Today's hearing culminates PSI's 10-month bipartisan review of DOJ's prolonged failure to implement the Death in Custody Reporting Act (DCRA). I want to first thank the families of individuals whose lives were lost during DOJ's failed implementation of DCRA for coming today to discuss their stories.

Congress passed DCRA with significant bipartisan support in 2000 and again in 2014. The law requires DOJ to gather annual data on the demographics and circumstances surrounding deaths of inmates in state and local jails and prisons. Proper implementation of DCRA could have provided DOJ, Congress, and the families with information on how inmates died in American prisons and jails and inform potential reforms if necessary. Since 2014, however, DOJ has repeatedly failed to properly implement and carry out its responsibilities under DCRA.

Transparency and accountability are necessary for effective congressional oversight. Unfortunately, as we experienced in our previous investigation of the U.S. Penitentiary Atlanta, PSI faced prolonged and continued obstruction by DOJ of its investigation into the Department's compliance with DCRA. Throughout this Congress, DOJ has displayed a continued disdain for the Subcommittee's investigatory work and congressional oversight generally. The Department's lack of transparency is unacceptable.

As a result of DOJ's unwillingness to fully cooperate with our investigation, the Subcommittee relied on the work of audit and investigatory agencies—namely the Government Accountability Office (GAO) and the DOJ Office of the Inspector General—to obtain basic information about DOJ's compliance with DCRA. These agencies have uncovered troubling issues with DOJ's DCRA compliance such as incomplete and missing death in custody data. I look forward to discussing these matters today and I thank them for their work, and I thank the witnesses for their testimony.

Testimony of Vanessa Fano

Before the Homeland Security and Governmental
Affairs Committee (HSGAC) Permanent Subcommittee on Investigations (PSI)

Hearing on "U.S. Department of Justice's ("DOJ")
Implementation of the Death in Custody Reporting Act"

Thank you, Chairman Ossoff and Ranking Member Johnson, for the opportunity to testify before you today. My name is Vanessa Fano, and my brother is Jonathan Louis Fano. I am testifying today because over five (5) years ago, in Baton Rouge, Louisiana's jail, I lost my brother to suicide.

I. Introduction

I am not a lawyer. I have, however, learned a lot about the criminal legal system and its utter disdain for the mental health needs of people in jail. On October 31, 2016, Baton Rouge police arrested my brother even though he was obviously hallucinating and very mentally ill. Through litigation filed on behalf of my mother, I learned that rather than take Jonathan to a hospital, police took him to the East Baton Rouge Parish Prison, which is Baton Rouge's jail. My testimony will focus on what I learned about the conditions of confinement for people in that jail, including my brother, who are detained pretrial—awaiting trial and presumed innocent. My brother, like every other person held in Baton Rouge's jail, deserved to be treated with basic human dignity. His death highlights the importance of the Death in Custody Reporting Act ("DCRA") because of the need for transparency in our jails and prisons.

II. Lack of Transparency

Since my brother's death, I have learned that Baton Rouge's jail is one of the deadliest in the country. At least 48 people, including Jonathan, have died in the jail since 2012. Rather than this information being readily available to the public, however, advocates have had to cobble together the information from both public sources and the media.[1] One expert estimates that the death rate at the jail when Jonathan died there was more than twice the national average.[2] It is

[1] The number of fatalities was reconstructed from public sources and includes deaths in the jail's work release program. A 2018 report by The Promise of Justice Initiative reported 11 deaths for 2012 through 2013. Incarceration Transparency reported 29 deaths in the East Baton Rouge Parish Prison and East Baton Rouge Work Release Program from 2014 - 2019. Fair Fight Initiative researchers relied on articles in The Advocate and brproud.com to identify eight people killed from 2020-2022. *See Incarceration Transparency, Louisiana Deaths Behind Bars* (n.d.), https://www.incarcerationtransparency.org/?page_id=277; Shanita Farris and Andrea Armstrong, *Dying in East Baton Rouge Parish Prison*, The Promise of Justice Initiative (June 2018), https://static1.squarespace.com/static/5fe0e9cce6e50722511b03cc/t/600895d13eefba64a65bbc53/1611175377849/Dying-in-East-Baton-Rouge-Parish-Prison-Final.pdf; and Jacqueline Derobertis, "Man Awaiting Trial at East Baton Rouge Parish Jail Dies after Staff Find Him Unresponsive in Cell," The Advocate (March 10, 2022), https://www.theadvocate.com/baton_rouge/news/article_24863d9c-a0ab-11ec-856f-93361ecdaae2.html.

[2] *See*, Exhibit A, pp. 27-28 (Dr. Homer D. Venters expert report, *Zavala v. City of Baton Rouge*, No. 3:17-CV-00656-JWD-EWD, (M.D. La. Jan. 3, 2020)).

my firm belief that had the information about Baton Rouge's jail high death rate been publicly available, my family and I would have done everything we could have to secure Jonathan's release prior to trial.

II. Punishment Prior to Any Conviction

My brother took his life after more than three (3) months in the Baton Rouge jail. Documents provided by the jail and its private, for-profit health care provider reveal that Jonathan spent almost every day of his detention in the Baton Rouge jail in solitary confinement. Prevailing science and the leading carceral health care accreditation agency acknowledge that people with mental illness should *never* be held in solitary confinement.[3] In addition to debilitating isolation suffered by my brother, the Baton Rouge jail subjects all people detained there to "deplorable" conditions generally.[4] Although never convicted of any crime, Jonathan was punished by the inhumane and unjust conditions in the jail.

III. My Pain

No amount of time can truly heal what I share with you today. Jonathan was so kind, he felt guilty killing a bug. He once took the bus downtown to babysit my kids, even though it was his birthday. Jonathan would spend hours listening to my problems and would do anything to support me. But at the time he needed the same support, no one responsible for his care, custody, and control gave it to him.

Jonathan suffered from schizophrenia and paranoia, for which he sought professional help and support from his family. He was never any type of threat or danger to us, or others. In October 2016, Jonathan was arrested in Baton Rouge, Louisiana while having a mental breakdown and taken to its jail.

In his ten weeks in pretrial detention, Jonathan never received a thorough mental health evaluation. After cutting his own wrists, he was placed in isolation. Despite our frequent phone calls, our family was repeatedly told that Jonathan did not want to speak with us. It was only on Christmas Day that we heard from Jonathan, who told us he wasn't allowed to call us.

During that phone call, we learned about Jonathan's attempt on his own life. But we could not get the details before the for-profit phone system cut off our call, even though we provided more funds to continue. We trusted the system.

We trusted the system when it provided us with Jonathan's court date; we flew across the country only to discover we were provided the wrong date. We trusted his public defender would be advocating for Jonathan's mental health care and release, and the advice to wait just a little longer in custody to resolve the case. We trusted the Baton Rouge Sheriff's Office, who

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[3] The National Commission on Correctional Health Care notes that "persons with mental illness should be excluded from solitary confinement for any duration." https://www.ncchc.org/solitary-confinement-isolation-2016/

[4] *See*, Exhibit B, p. 7, (Jeffrey A. Schwartz expert report, *Zavala v. City of Baton Rouge*, No. 3:17-CV-00656-JWD-EWD, (M.D. La. Jan. 3, 2020)).

claimed that Jonathan was receiving the care he needed in detention.

On February 3rd, 2017, Jonathan hanged himself with a bedsheet in his cell. When we finally saw his lifeless body, the first time in ten weeks, he was handcuffed to an intensive care unit bed. It was only then we realized how wrong we were to place our trust in this system, which told us there was no fault after their own internal investigation of Jonathan's death.

It is only through our own insistence over the past five years that we have come to learn how hard Jonathan tried to receive help. How belittled he was. How no one believed him. How so many other people have died in this same jail under these same conditions. Each time I tell Jonathan's story, he feels farther away. I worry for the day I can never hear his voice, feel his warmth, or see his face again.

I tell you Jonathan's story for every family who has experienced the same. And I hope, in doing so, we can improve our beloved nation and prevent this from ever happening to another family again. Thank you.

EXHIBIT A

Homer Venters MD, MS
10 ½ Jefferson St.
Port Washington
NY, 11050

January 3, 2020

David J. Utter, Esq.
The Claiborne Firm, P.C.
410 E. Bay Street
Savannah, GA 31401

Dear Mr. Utter:

This is a preliminary report as to my opinions regarding the medical care and deficiencies in care in the case of Mr. Jonathan Fano. I have reviewed the materials provided to me and listed in the report in formulating my conclusions I have included the following in this document:

Attachment A: Written report of Dr. Homer Venters
Attachment B: Vita of Dr. Homer Venters (with fee schedule, list of cases, and statement of charges)

Please advise me if you require any further information.

Sincerely,

Attachment A

Dr. Homer D. Venters
10 ½ Jefferson St., Port Washington, NY, 11050
hventers@gmail.com, Phone: 646-734-5994

Re: Detainee death of Jonathan Fano in East Baton Rouge Parish Prison ("EBRPP")
Preliminary Report

PRELIMINARY STATEMENT

Systematic failures and gross deficiencies in the health care system for detainees at EBRPP directly contributed to the death of Mr. Fano. The systemic failures were known to public officials since at least January of 2015, when city manager William Daniel and Warden Dennis Grimes told the Metro Council the conditions at the jail were an emergency, especially for the mentally ill. Mr. Fano was precisely the type of person Daniel and Grimes warned the council about when he arrived at EBRPP in late 2016. He was identified as being in acute distress prior to his arrival at EBRPP and upon arrival, he should have been immediately assessed by health staff as needing a level of assessment and care beyond their capacity. Instead, health staff failed to review or incorporate Mr. Fano's presentation to police or his history of suicide attempts and he was

judged to be faking or exaggerating his symptoms. After he engaged in self-harm, health staff permitted Mr. Fano's transfer to solitary confinement[1] where his risk of suicide would have been greatly amplified due to the solitary confinement setting as well as the lack of basic suicide prevention measures. Health staff failed to provide meaningful care to Mr. Fano, even as his

[1] This report utilizes the term "solitary confinement"—also called "restrictive housing" and segregation" by U.S. Dept of Justice (USDOJ)—throughout and relies on the definition provided by the USDOJ. The USDOJ identified the three elements of restrictive housing as 1) Removal from the general inmate population, whether voluntary or involuntary; 2) Placement in a locked room or cell, whether alone or with another inmate; and 3) Inability to leave the room or cell for the vast majority of the day, typically 22 hours or more. Report available at https://www.justice.gov/archives/dag/file/815551/download EBRPP officials use "segregation," "isolation", and "disciplinary detention" when describing the conditions on the M and N lines.

condition worsened and he requested additional care. Finally, systemic failings in leadership, training, and supervision led to grossly incompetent and inadequate mental health care by jail health staff. These failings continued throughout Mr. Fano's stay, including the transition from Prison Medical Services ("PMS") to CorrectHealth East Baton Rouge, LLC ("CorrectHealth"). The continued placement of detainees with mental illness in solitary confinement, and the denial of basic health mental care by EBRPP staff to individuals detained in EBRPP and Mr. Fano represent gross departures from accepted medical practice in jails and reflect a systemic lack of concern for the survival and health of persons detained in EBRPP.

FACTS AND DATA CONSIDERED

I have reviewed documents produced by Health Management Associates ("HMA") in their assessment of health services in the EBRPP, publicly available information from the local city and parish government, depositions of HMA staff, various EBRPP and CorrectHealth officials, and Medical and Security records for Mr. Fano and others detained in EBRPP. My report is based on the following files and information;

- Tour of EBRPP 6/7/19
- 20160223 HMA notes
- 2016 PPt draft 1
- 2016 PPt final
- 2016April Batia Notes-NCCHC med std
- 20160421 Batia notes—NCCHC mental health
- Batia Karen (depositions)
- Raba M.D. Jack (depositions)
- Follenweider, Linda (depositions)

- Police arrest documents of Mr. Fano
- Mr. Fano's medical records from EBRPP, including documents generated from PMS and CorrectHealth.
- EBRSO incident reports from investigations of Mr. Fano's death and other detainee deaths at EBRPP provided by sheriff defendants in discovery
- Security video of N line
- Beatrice Stines (depositions)
- Linda Ottesen (*Lewis* deposition)
- EBRPP security logs
- PMS policies
- CorrectHealth policies
- U.S. Department of Justice Report and Recommendations Concerning the Use of Restrictive Housing_Final Report_January 2016
- NCCHC Position Statement: Solitary Confinement (Isolation) April 2016
- Joshua Boxie (*Lewis* deposition and affidavit)
- Byron Maxon (*Lewis* deposition and affidavit)
- Joseph Jones (*Lewis* deposition and affidavit)
- Christopher Haney (*Lewis* deposition and affidavit)
- Corey Pittman (*Lewis* deposition and affidavit)
- Brodrick Samuel (*Lewis* deposition and affidavit)
- Rani Whitfield (depositions)
- Chad Guillot (depositions)
- Dennis Grimes (depositions)

- Shawn Robinson (affidavit)
- Charlie Bridges (depositions)
- Lisa Burns (deposition)
- William Daniel (depositions)
- Joyce Brown (deposition)
- Andrea Brown (deposition)
- Jean Llovet (deposition)
- Cathy Schley (deposition)
- Courtney Eichelberger (deposition)
- Tamekka Green (deposition)
- Danielle Thomas (deposition)
- Vincent Bradley (deposition)
- Sharon Allen (deposition)
- Kimberly Bates (deposition)
- Tonyala Cannon (deposition)
- Yolanda James (deposition)
- Gregory Doane (deposition)
- Natasha Jones (deposition)
- Stephen Kissinger (deposition)
- Carlo Musso (deposition)
- Rintha Simpson (*Lewis* deposition)
- Walter Smith (deposition)
- Susan Hatfield (deposition)

- Frank Brooks (affidavit and deposition)
- Daniel Hinton (affidavit and deposition)
- Emanuel Jones (affidavit)
- Metro Council Meeting video, Jan. 14, 2015, Item 13P and Q Part I, and Aug. 26, 2016
- CorrectHealth staff timesheets
- PMS final approved budgets 2015-19
- CorrectHealth 20190311 discovery production—contracts
- Public records regarding CorrectHealth, HMA and Baton Rouge communications about health care at EBRPP
- CorEMR-EBRP – Reports staff activity reports provided by CorrectHealth in discovery
- *Lewis* payroll for May 2015

EBRPP TOUR OBSERVATIONS

I toured the EBRPP facility on 6/7/19 with attorneys for both the defendants and plaintiffs in the Fano case. During that tour, I was able to visually inspect the intake area, medical clinic, infirmary, pharmacy room and Q, N, M, E housing areas. I was unable to ask questions of staff working in the facility or detainees. I have listed concerns about safety and health of EBRPP detainees from this tour limited to those relevant to the case of Mr. Fano.

1. **Seriously mentally ill detainees are held in solitary confinement cells that increase their risk of death.** Both the N and M lines appear to function as solitary confinement, with detainees held in a cell 23 to 24 hours per day. There is a white board outside one of the units that has names of patients and their apparent suicide watch status listed. None of

the patients or cells designated as SW (presumed 'suicide watch') or MHO (presumed 'mental health observation') has an officer stationed outside their cell to ensure constant observation. The cells are not visible from the central bubble where officers are stationed, and no officers are stationed in the actual housing areas. No video surveillance into cells appears to exist. Each of the units has one cell in the bubble area, the function of these cells or reason for having people in them was not clear. Inside the units, it appears as if detainees rarely exit their cells and there does not appear to be any group or congregate activity for these detainees in solitary confinement. Mental health encounters with the EBRPP psychiatrist appear to occur through the bars of the cells. Each cell has numerous suicide risks including the open bars, more than one of which had cloth ties affixed to bars at the time of our tour. In addition to the bars, the shelves and tables in each cell also pose suicide risk as easy anchor points for suicide by hanging. Some of the cells were extremely dark due to the window coverings, and some have considerably more light. These units have a foul smell from trash, rotting food or body odor and the cells are in disrepair with substantial rust and peeling paint. The catwalk between the lines have no lights in them and while the lights in the housing areas illuminate the walkways of each housing area and the front 2-3 feet of the cells, the parts of the cells farther back from the front are very difficult to see into. In addition, many of the windows in the catwalk are tinted, making it even more difficult to see past the well-lit walkways of the housing units into the cells.

2. These units pose significant risk for suicide and self-harm in two ways. First, the practice of solitary confinement is associated with self-harm and is discredited as an acceptable practice for people with mental illness.[2] Second, these units have virtually none of the

[2] In April of 2016, the National Commission on Correctional Health Care (NCCHC) took the position that solitary confinement—defined as "the housing of an adult or juvenile with minimal to rare meaningful contact with

standard suicide prevention measures in terms of physical plant or staffing. Placement of persons with mental illness into these units significantly increases their risk of death and self-harm. These are the most dangerous units I have observed in an American jail or prison.

HMA FINDINGS AND EVIDENCE RELEVANT TO DETAINEE DEATHS

HMA was retained by the Parish of East Baton Rouge in 2016 to conduct an assessment of the health services in EBRPP and make recommendations about how to improve access to and quality of health services. In the time since Mr. Fano passed away due to his injuries sustained at EBRPP, at least 15 more individuals died at EBRPP or shortly thereafter in a local hospital after being transported from EBRPP.[3] Many of the observations made by HMA and their recommendations are directly tied to risks of injury and death posed by ongoing practices by health and security staff and structural barriers to evidence-based health services in EBRPP. Each of the three categories of the HMA assessment (access to care, quality of care, leadership) revealed gross deficiencies that significantly increase the risk of detainee deaths. The testimony from health staff, the Warden, and patients, and documents and video provided in discovery, support these concerns.

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other individuals"—for greater than 15 consecutive days "is cruel, inhumane, and degrading treatment, and harmful to an individual's health." NCCHC takes the position that individuals with mental illness "should be excluded from solitary confinement of any duration." NCCHC Position Statement: Solitary Confinement (Isolation) at https://www.ncchc.org/filebin/Positions/Solitary-Confinement-Isolation.pdf (accessed Dec. 23, 2019). Jonathan Fano had a mental illness and was segregated in EBRPP's N wing for 92 consecutive days.

[3] Including Mr. Fano, 17 people have died at EBRPP or shortly thereafter in a local hospital after being transported from EBRPP since CorrectHealth took over from PMS. Included in the 17 deaths is Edward Jones, a diabetic mentally ill man who was found by CorrectHealth LPN Danielle Thomas at 7:30 am on Jan. 9, 2017 lying on the floor of his cell in N wing "moaning and grunting as he always does." When she returned at 11:10 am, he was "very limber and appeared to be suffering from a medical emergency." After being transported to the infirmary, he died a few minutes later. Bates No. EBRSO_002600-27. Thomas is the same CorrectHealth nurse who did not verbally interact with Mr. Fano in front of his cell during pill call on Feb. 2, 2017, instead claiming to visually monitor him from the reflection of the catwalk during morning pill call the day he hanged himself. It is unclear whether she was part of the CorrectHealth staff urged to "show more compassion" in response to medical emergencies by CorrectHealth leadership during one of the inconsistently held health care staff meetings.

Suicide prevention is another aspect of care that HMA identified as grossly deficient at EBRPP. Suicide is the leading cause of death in U.S. jails and thus, suicide must be a top priority for every health service in jails. HMA's assessment makes clear that no evidence-based suicide prevention program existed at the time of their work and that no updated policies regarding suicide prevention, tracking and quality assurance of the suicide prevention care provided or regular incident review of self-harm and suicidal behavior was in place. Although CorrectHealth's suicide prevention policies were an update from PMS, it is clear that the procedures and actual practices in place at EBRPP during Mr. Fano's detention were similarly grossly deficient. This failing is made more dangerous to the health and safety to detainees with mental illness because of EBRPP's policy of placing the mentally ill in M and N's solitary isolation cells, and HMA's findings that the bars of those cells are suicide hazards.

The lack of training identified by HMA is readily apparent in the confusion about how or whether any assessment of individuals on the N and M lines was to occur on a daily basis. One of the rudimentary safety measures employed in solitary confinement settings is to have health staff view and document the health status of every patient every day, so as to detect patients in distress or who are decompensating. EBRPP's Health Services Administrator ("HSA") in 2015, Linda Ottesen, stated in her deposition she personally changed the facility policy in 2012 to mandate that every nurse interact with and receive a response from every person, even those who were not receiving medications. She stated that a record of each of these interactions would be kept in the Medication Administration Record (MAR) books under the purview of health staff. This process was replicated in the Electronic Medical Record (EMR), per Mrs. Ottesen, so that a record of every interaction would be recorded every day, showing that nursing staff were conducting these interactions with all detainees as they made their pill call rounds, not only those receiving

medications. Deposition testimony of nursing staff, however, make clear in their testimony that there was no training on this process and no tracking of these individual assessments actually occurred, whether on paper or in the EMR. They report a mix of practices including either calling out to every cell as to whether or not the person inside was on medications, or only stopping to talk to people known to be on medications. This lack of basic rounding on patients known to have increased risk for suicide is further compounded by the practice of keeping people locked in their cells for up to 24 hours per day, without any time out of cell, which violates every established guideline of correctional practice. Deposition testimony, a review of documents provided by the sheriff and medical staff, and the limited video review available indicate that detainees on N line, including Mr. Fano, received no more than 20 minutes a day outside of their cells, and were never permitted access to the outdoor recreation area. In addition, the lack of training and confusion found by HMA continued when CorrectHealth assumed responsibility.

HMA findings and tour of EBRPP indicate a lack of timely access to care in the M and N lines where Mr. Fano was held and which operated (and continue to operate) as solitary confinement units, where serious mentally ill patients are held in their cells 23 or 24 hours per day without access to meaningful mental health care, recreation, social contact or any stimulation other than the yelling of other similarly isolated detainees. This practice of holding patients with serious mental illness, including those who were on suicide watch, in solitary confinement, was well known by all health and security staff, including CorrectHealth staff.[4]

HMA reported multiple other failures and gaps in quality assurance and improvement in the EBRPP health service. HMA reported that missed medications rate was 22% and that many

[4] Particularly troubling is CorrectHealth's leadership's refusal to even acknowledge that the conditions on N lines amount to solitary confinement, that they have any responsibility to attempt to influence the practice of placing the mentally ill on the N lines, or ameliorate the suffering of the ill detainees placed there.

patients who required specialty care were not taken for appointments. In addition, HMA noted gross deficiencies in basic medical and mental health care including suicide prevention, excessive use of antipsychotic medications for sedation of patients and chronic care, and a complete absence of mental health programing. These systemic failings appeared to stem from a lack of basic training and competency of staff as well as failure to utilize health outcomes & medical utilization data that was available in the EMR but never accessed. There is little evidence that CorrectHealth implemented any additional trainings or systems to address these deficiencies in care in any meaningful way during the time Mr. Fano was in EBRPP[5] and in fact, the overall rate of death would increase after CorrectHealth assumed responsibility (see findings below).

Two examples of how these deficiencies in the EBRPP health service can contribute to death are chronic care and suicide prevention. Persons in correctional settings are well-known to have rates of chronic medical problems, at rates far in excess of community rates. Many of the highly prevalent medical problems in correctional health settings, including epilepsy, diabetes, cardiovascular disease, hepatitis C and acute substance withdrawal can be fatal when left untreated and represent a significant portion of preventable deaths in jails. Appropriate treatment of chronic diseases behind bars requires a plan of care that is interdisciplinary and follows a protocol of diagnosis, treatment, and education. HMA reported that no such plans or programs for chronic diseases existed, which would significantly increase the likelihood that persons with these problems would miss medications or be denied care that was life-sustaining or life-saving. Perhaps the most telling example of how little things changed with CorrectHealth's assumption of

[5] The one nod to the serious issues presented by placing the mentally ill in solitary confinement—CorrectHealth's policy on segregated inmates—requires screening before placing individuals with health needs in solitary confinement and regular monitoring by health staff. Deposition testimony from CorrectHealth staff indicates that the policy was not implemented at EBRPP for many months after CorrectHealth took over on January 1, 2017, and Mr. Fano's medical records are devoid of the finding from any prescreening and segregation logs, making it clear that the policy was directly contradicted by the practice and did nothing to protect him.

responsibility for health care at EBRPP are the deaths of Edward Jones and Mr. Fano in January and early February of 2017.

Leadership: The third major category of gross deficiencies reported by HMA that are implicated in the risk of detainee death is medical and administrative leadership. This category is relevant to preventable deaths of detainees because correctional health services rely on the teamwork of a medical director, nursing director, mental health director and health service administrator as the key leaders who will ensure that sound policies exist for health staff and that these policies are followed. Moreover, this ensures that quality assurance activities are in place to monitor performance and that quality improvement and death/incident reviews are also conducted in a way that improves problems that may be associated with inmate deaths. This lack of competent leadership in key positions would continue as CorrectHealth took over responsibility for health services and included the roles of health services administrator and director of nursing. Although CorrectHealth's corporate leadership took steps to fire or replace ineffective staff in those positions in early 2018, the changes came too late for Mr. Fano and others who died in 2017.

HMA reported that the health services lacked policies that were up to date, disseminated to and known by staff, and tailored to the actual facility (EBRPP) where they worked. CorrectHealth did not tailor its policies to EBRPP into mid-2018—more than eighteen (18) months after assuming responsibility for health care at EBRPP. HMA also identified that there was no full-time administrator assigned to the health service in 2016, despite obvious need, and that the medical director "serves as a spokesperson and is not involved in operational, supervisory, monitoring or quality improvement activities." HSA Ottesen testified she left in late 2015. As indicated in her deposition testimony when compared to the findings of HMA, her failings as a leader seemed to have contributed to, rather than help fix, EBRPP's grossly deficient health care

system. Deposition testimony of Dr. Bridges reveals that although he was at one point the Medical Director for PMS, for years prior to Mr. Fano's arrival at EBRPP he was not the Medical Director and no one assumed this critical role for years.

The HMA assessment paints a bleak picture of the health service of EBRPP as one that has been designed and run in a manner that clearly ignores basic standards of correctional health and operates in a manner that significantly increases the risk of preventable death by failing to conduct intake assessments, denying access to sick call and other types of health services and conducting operations without adequate leadership, policies and staffing. The most obvious and critical recommendation made by HMA was that the investment in the correctional health service of EBRPP would need to double, from a current (2016) annual budget of approximately $5 million to $10 million. This estimate was based on the patient profile of EBRPP detainees and the gaps in existing correctional health staffing and expected numbers of encounters. This doubling of investment would allow for the creation of a competent health service, with leadership, policies & procedures and quality promotion that represents the standard of care in correctional health, whether through a new vendor or academic or community health partnership. Failure to follow HMA's primary recommendation regarding resource allocation would leave in place many if not all of the heightened risks of death experienced by detainees in EBRPP.

When CorrectHealth assumed responsibility for care in January 2017, it is also apparent that they failed to ensure that leadership would be present and involved in the transition, including a health services administrator and medical director working on January 1, 2017. In addition, an analysis of staffing levels highlights a central problem identified by numerous parties and which CorrectHealth chose to ignore, the lack of sufficient health staffing. When compared to staffing levels before January 1, 2017, virtually every level of health professional was utilized for fewer

hours per week after the transition than was present before. This chronic understaffing was already identified as a central failing by HMA and CorrectHealth made this failure even more pronounced. According to the deposition testimony of Dr. Rani Whitfield in the *Zavala* matter, current nursing staff report little to no change on this critical issue up to and including late 2019.

TIMELINE

Prior to his incarceration, Mr. Fano had previously been diagnosed with bipolar disorder and depression and had longstanding care that included the psychotropic medications risperdone and olanzapine (antipsychotics) and trazodone (antidepressant). Mr. Fano was arrested on October 31, 2016 for disorderly conduct and other misdemeanor charges stemming from erratic behavior on the streets of Baton Rouge. He had apparently been on a cross country bus and because of auditory hallucinations, exited the bus in Baton Rouge and was quickly approached by Police who documented that he was "naked and running around swinging his penis," speaking to an imaginary person "he kept saying him and Tatianna (Fake Imaginary person) was cross dressers and trying to find a show to make money." Police took Mr. Fano directly to EBRPP where he was booked.

Mr. Fano's medical intake questionnaire on November 1, 2016 by Sharon Allen includes that he replied "yes" to whether or not he was on any medications and "no" to all the questions regarding illicit drug use or mental health problems. That same day EBRPP security records indicate that Mr. Fano engaged in self-harm by cutting his wrists and the response of facility security staff was to charge him with a disciplinary infraction for "self-mutilation" that would result in two weeks in solitary confinement. Mr. Fano's self-harm prompted a transfer to a local hospital evaluation in the early hours of November 2. The Emergency Medical Request filled out by EBRPP health staff documents that Mr. Fano has no mental health history and also that he engaged in suicidal self-harm and was reporting hearing voices. Nurse Bradley initiates a suicide

watch for Mr. Fano, indicating that a suicide attempt has occurred and the presence of suicidal ideation. Upon his return to EBRPP, Mr. Fano was placed on suicide watch on the N line. A clinical encounter with social work staff was scheduled for November 2 and ultimately deleted on November 6 without occurring. A notation in the documentation indicates that the encounter was overdue before being deleted. On November 3, 2016, EBRPP psychiatrist Dr. Robert Blanche conducted a cell side evaluation of Mr. Fano and concluded that Mr. Fano was not suicidal and that he should be prescribed Olanzapine and Seroquel for bi-polar depression and sleep disorder respectively. No record exists of an out of cell encounter between Dr. Blanche and Mr. Fano on this date. On the following day, November 4, an appointment is made for Mr. Fano to see a psychiatrist one month later, but this appointment was not kept and ultimately labeled as 'not seen'.

On November 25, while still housed on N line, Mr. Fano submitted a request for care with the complaint that his medications "don't work anymore" without eliciting any apparent mental health services or care. Mr. Fano submitted another request for care on December 18, still housed on N line, with the complaint that "I'm having really bad anxiety and depression. Feels as if the walls are closing in, also having really bad thoughts of my time here." On December 22, Mr. Fano was moved to another cell on N line, also solitary confinement. The same day, a health encounter was scheduled for Mr. Fano with the reason of "Anxiety/Depression" which was not kept and was ultimately labeled as not seen. Another clinical encounter for Mr. Fano is documented for December 26 with the reason "Need to see Psych" but there is no clinical record of this encounter with Dr. Blanche.

On January 1, 2017, CorrectHealth assumed responsibility for health care at EBRPP. Mr. Fano had a clinical encounter on January 3, 2017, now under the auspices of CorrectHealth. This encounter documented complaints of anxiety, depression and auditory hallucinations and included

a plan of prescribing the antihistamine hydroxyzine. Another encounter for Mr. Fano occurs on January 11, 2017 in which Mr. Fano is documented to be not taking his medications and not eating. A note by C. Schley indicates that Mr. Fano is thought to be faking or exaggerating his symptoms and that he is stable. Mr. Fano's medications are listed as Zyprexa and Seroquel and that Mr. Fano is reporting a history of self-harm and suicide attempts and that he is currently experiencing auditory hallucinations. This encounter includes reference to a suicide attempt involving Mr. Fano cutting his wrists that occurred in EBRPP in November 2016 and which required hospital transfer. The note goes on to characterize Mr. Fano as either faking or exaggerating his symptoms, in part because of his subdued mood, orientation and because he is unable to hear the auditory hallucinations with sufficient clarity to know what is being said. The note records "[t]hen he tells me he can't tell me what they are saying. NO outward indication of responding and reports hearing voices INSIDE his head." And "I suspect some faking bad or exaggerating his condition on his part is possible. [P]resents as stable overall." No mention of the assessment conducted after his documented suicide attempt in November 2016 is included and no mention of the observations of police officers at his arrest is included. This encounter is labelled as a "Mental Health SOAPE [sic] Note" and the same paragraph that includes the sentences above is repeated in over 10 fields, apparently copied and pasted or otherwise entered multiple times. In the area that appears to reflect the assessment by this provider, there is an entry "Adult Antisocial Behavior (r/o mood d/o by report only; r/o psd r/o psychosis nos by report only; r/o personality d/o nos)." A referral to Dr. Blanche, now with CorrectHealth, is included in this encounter as is continuation of hydroxyzine.

On January 18, 2017 Dr. Blanche conducts his second cell side encounter with Mr. Fano and assesses that he likely does not suffer from serious mental illness and that his antipsychotic medication should be discontinued. Testimony of other detainees indicates that Mr. Fano was

experiencing a mental health crisis and that he asked others for razor blades. Mr. Frank Brooks, who was detained at the same time as Mr. Fano, provided a sworn statement that "Mr. Fano was also talking to himself, saying things out loud to no one in particular, like he was hearing and talking to voices in his head. It was obvious he wanted to hurt himself, so obvious that 4 or 5 other detainees and I told guards and medical staff that Mr. Fano needed to be moved to a cell where he could be closely watched so he did not hurt himself. Guards and medical staff would respond by saying 'he'll be alright' or 'don't worry, he's ok.' I did not understand why they kept him so far away from the cage, where staff could not see him unless they did rounds." Mr. Brooks also reported that security staff often failed to conduct their basic security rounds and that detainees were often confined to their cells for 4-5 days straight.

Mr. Emanuel Jones, who was also detained at the same time as Mr. Fano and came from another part of the jail to clean the N and M lines, reported very similar concerns about Mr. Fano, stating in deposition testimony "Mr. Fano always talked about killing himself" and "I told Dep Monroe that he needed to get Fano help and move him to a cell closer to the cage so guards could watch him." Mr. Jones also stated that "Guards do not do their rounds and counts like they are supposed to." A third person detained at the same time as Mr. Fano, Daniel Hinton, reported that Mr. Fano was expressing suicidal ideation including stating "He would talk out loud to himself as he stepped off, and stating 'man I can't handle this. Give me a razor blade. I want to kill myself.'" Mr. Hinton also reported that security staff did not conduct their required rounds.

On February 2, 2017, Mr. Fano is found hanging in his cell on N line, transported to Lady of the Lake Hospital where he died three days later.

SPECIFIC FINDINGS

The following represent major deviations from the standard of clinical care that is expected in correctional health services. Both PMS and CorrectHealth are implicated in these findings as the lapses in mental health care span the transition of one provider to the next on January 1, 2017, and there is a clear and profound lack of access to mental health services under both providers. Review of depositions by CorrectHealth staff make clear that CorrectHealth failed to appreciate and address clearly visible deficiencies in care when they assumed responsibility for the provision of health services in EBRPP.

1. Lack of meaningful response by Baton Rouge Police Department to a behavioral health crisis. Based on the initial reports via 911 and their own observations in the field, Baton Rouge Police should have arranged EMS transport of Mr. Fano to an emergency room for evaluation of his behavioral health emergency. There, physicians could have assessed the relative contributions of mental health and acute intoxication to Mr. Fano's mental status and initiated treatment. The police report by the Baton Rouge Police Department includes multiple observations by their own staff and others that Mr. Fano was acting in a bizarre manner that placed him and others at risk and that he was hallucinating and otherwise 'acting crazy.' The narrative reported by police officers in their report was that Mr. Fano was under the influence of alcohol and/or narcotics, without a single mention of any mental health concerns. Police Department staff then relied on a 'clearance' by EMS personnel for transport of Mr. Fano to the jail without medical or psychiatric evaluation of his potentially suicidal, psychotic or otherwise life-threatening status. In fact, the documentation of police that Mr. Fano was transported because of his "horribly bad behavior" supports the concerns

that police staff and their supervisors lacked the training to appropriately respond to a clear case of a behavioral health emergency.

2. Failure to redirect Mr. Fano to a hospital setting during admission to EBRPP. Both EBRPP security and health staff should have read and acted on the police arrest reports which clearly documented that Mr. Fano was in the throes of a behavioral health crisis that required evaluation by physicians in a hospital setting. One of the core responsibilities of security and health staff conducting intake assessments before a detainee is housed is to identify persons too ill or at risk of death who require immediate medical or psychiatric evaluation in a hospital. There is no indication that any EBRPP staff reviewed police arrest documents or considered the poor health of Mr. Fano during entry to the jail. The PMS staff member who conducted the health assessment on November 1, 2016, S. Allen, did not include the alarming observations of behavioral health crisis from the police arrest reports in the clinical notes and there is no evidence that police reports or observations were ever reviewed by her or any other EBRPP. In addition, despite including that Mr. Fano was reporting auditory hallucinations and that he had a "suicide gesture" at an unspecified moment in time, C. Schley makes an assessment on 1/11/17 that Mr. Fano is faking or exaggerating his symptoms, largely based on the clinically unsound rationale that Mr. Fano is experiencing auditory hallucinations that he cannot discern the words he is hearing, that he is not exhibiting any outward signs of these hallucinations and that he reports the voices as originating inside his head. Auditory hallucinations are extremely variable, in their perceived clarity, origin and level of threat, not only from one person to another, but from moment to moment in a single patient.[6] A more appropriate and

6 Flavie Waters, PhD Psychiatric Times. Auditory Hallucinations in Psychiatric Illness March 10, 2010 Volume: 27 Issue:3 https://www.psychiatrictimes.com/cme/auditory-hallucinations-psychiatric-illness.

evidence-based approach would have been to elicit a standard history about whether these auditory hallucinations were ever perceived as threatening by Mr. Fano or directed him to harm himself or others and what the impact of therapy and medication was on them. In addition, there is no documented effort to reconcile these auditory hallucinations with Mr. Fano's history of suicide attempts, which are recorded as recently as 2016 in EBRPP. This clearly deficient assessment that Mr. Fano is faking or exaggerating symptoms is copied and pasted into more than ten fields in his mental health notes, including in domains that are not intended for assessments but are for objective data gathering, such as speech, perception or thought coherence. This indicates that C. Schley's judgment that Mr. Fano was faking or exaggerating his symptoms precluded the objective collection of data through a mental health assessment. A history of suicide attempts and current behavioral health crisis documented by police should have led CorrectHealth health staff to immediately refer Mr. Fano to a hospital for evaluation.

3. Failure to provide meaningful mental health care while incarcerated in EBRPP. Having failed to redirect Mr. Fano to a hospital setting, PMS and EBRPP security staff then failed to provide adequate or timely care for his obvious, serious behavioral health concerns. During his detention, Mr. Fano was briefly transferred to the hospital and when returned, mental health staff approved his placement in solitary confinement in the N/M lines of EBRPP on suicide watch. These housing areas were (and continue to be) administered with limited access to mental health services and include the practice of solitary confinement, which is known to exacerbate existing mental health problems and is associated with high rates of self-harm and death. It appears that Mr. Fano's initial encounter with a psychiatrist (Dr. Blanche) occurred on the third of November, not in a clinical setting but through the

bars of Mr. Fano's cell. During this encounter, Dr. Blanche assessed Mr. Fano as not being suicidal and ordered his suicide watch to be stopped but did not order for his removal from solitary confinement. This is the only recorded encounter between Mr. Fano and Dr. Blanche until the new year and given his history of suicide attempt, recent self-harm, recent medication changes and auditory hallucinations, Dr. Blanche should have seen Mr. Fano at a minimum of one week after the initial encounter and should have also ordered his removal from solitary confinement and that his clinical encounters occur in a clinic setting, not through the bars of his cell. Despite his well-documented mental health history and active problems, the mental health service appears to ignore the need for clinical care of Mr. Fano, scheduling and deleting multiple encounters without actually seeing him. On December 18, 2016, Mr. Fano's request for care makes clear that his mental health is worsening in solitary confinement: "I'm having really bad anxiety and depression. Feels as if the walls are closing in, also having really bad thoughts of my time here." The response of Mr. Fano's repeated requests for more effective care was to decide on withdrawal of his medications. Deposition testimony by Dr. Bridges indicates that his referral of Mr. Fano to see Dr. Blanche on November 4, 2016 did not include any pre-determined time frame. This represents an additional failure in the mental health service since timeframes for mental health referral should be divided into categories that include known timeframes, with commonly used categories being routine (within 7 days), urgent (within 24 hours) and stat (immediate). Multiple appointments were made and cancelled for Mr. Fano to see Dr. Blanche, and he was not actually seen again by Blanche until January 18, 2017, over two and a half months after the referral by Dr. Bridges. This is exactly the type of systematic

risk that incoming CorrectHealth should have identified and addressed, especially given the alarming assessment conducted by HMA.

4. Failure of the Parish and CorrectHealth to institute basic remedies for obvious deficiencies in the mental health services upon assuming responsibility for health services in EBRPP. The deposition of Dr. Bridges makes clear CorrectHealth failed to implement even the most basic elements of assuming care in their transition into EBRPP. Having overseen, led and participated in many such transitions, I am struck by the lack of sign out or briefing on the most seriously ill or high-risk patients by CorrectHealth. When one vendor assumes responsibility for care, it is standard, and in the best interests of patients, staff and the vendor alike, to compile a list of the patients with the most serious health problems and ensure their assessments, treatments, medications etc. are not interrupted in the transition. This would include patients with active cancer, heart disease, diabetes, recent hospitalizations, those in withdrawal from any substance use and those with any suicidal ideation or serious mental illness. Dr. Bridges testified in deposition that he was never contacted by CorrectHealth to perform this type of review. In fact, he testified that he was never contacted by CorrectHealth for any reason in the months leading up to the transition on January 1 2017, or for any time after the transition. Dr. Bridges also testified that the October 2016 departure of the only other physician, Dr. Whitfield, left a gap that was not addressed with hours worked by another physician or by him. The deposition of Ms. Stines, Director of Nursing until the end of 2016, indicates that the Parish was not providing adequate funding to meet basic needs of patients, and that the acting HSA had told her that he would not be the one to obtain supplies, but that she would need to advocate herself for basic supplies and equipment. As she stated "The demand was great for the supplies. It was

greater than the utilization of the supplies. We needed more supplies. We were not getting any equipment and stuff fast, you know, like we needed it." A similar lack of resources for staffing was also reported by Ms. Stines: "We needed it, and we needed more members, more staff members." The deposition of Mr. William Daniel supports the lack of oversight and provision of resources by responsible parties. He identified EMS as the organization responsible for oversight of CorrectHealth and testified in his deposition and recorded in previous notes regarding the HMA findings that the Parish was not providing adequate care and needed to develop a new model to improve the quality of care that would include quality metrics tracked in an electronic medical record. He also testified in his deposition that "HMA pretty much confirmed what I already believed." Parish officials had publicly declared the situation in EBRPP to be a state of emergency and that the consequences of failure to dramatically increase funding and access to care would be the deaths of more people. At the Metro City Council meeting January 2015, the Chief Administrator stated that "We've had mental health patients die in the prison" and that the conditions in EBRPP represented "a serious, serious situation" and alerted officials that "people are in a position where they can be harmed or lose their life" and that increased funding for health services was "life or death" for the mentally ill in the jail. At the same meeting, the EBRPP warden labeled the jail conditions as "very deplorable as far as mental health is concerned."

Nonetheless, there is no evidence that the Parish or CorrectHealth undertook efforts to improve conditions of care or even effect a safe transition of service delivery in January 1, 2017. CorrectHealth nurse practitioner Joyce Brown reported in her deposition that she could not recall a death review meeting for Mr. Fano or receiving a report or findings on this death, despite the lack of these death reviews having been profiled as a core failure by

HMA.[7] She further reported in her testimony that the 11-day delay in Mr. Fano's Seroquel order being approved by her was not out of the ordinary or concerning. Jean Llovet, the director of clinical services for Louisiana and a self-described CorrectHealth loyalist, testified that there was a period of time during the transition during which people did not receive their medications due to an unknown IT issue. The HSA for CorrectHealth during the time of the transition, Natasha Jones, reported in her deposition that she did recall a death review being done for Mr. Fano's case that involved some clinical staff and the CorrectHealth attorney, but that she did not recall any errors or discussion about the quality of care in his case. She further testified that among the 4 or 5 death reviews that she was part of for CorrectHealth at EBRPP, she did not recall any instance where the care diverged from community standards. Nurse Tamekka Green, who worked into 2018 with CorrectHealth at EBRPP, reported serious staffing shortages in the facility as well, specifically nurses that were dedicated to ensuring patients received their medications.

The lack of CorrectHealth action to address risks to patients was especially grave in the solitary confinement units of the N and M lines. Nurse Danielle Thomas testified in her deposition that when Mr. Fano died, nurses were not conducting segregation rounds, e.g. documenting the status of each person at least once per day, which is a standard practice in jail and prison settings. She also testified that she did not walk all the way down Mr. Fano's cell block during pill call on the morning of the day Mr. Fano hanged himself. Nurse Vincent Bradley reported a different practice, of walking down the cell block every time pill call was conducted, but the variation and lack of understanding among these nurses makes clear that when CorrectHealth assumed responsibility for care, they did not

[7] I understand that CorrectHealth claimed to have performed a mortality review on Mr. Fano. This report is preliminary in the sense that it was written without the benefit of that document.

establish any meaningful practice to assess and document the health of people held in solitary confinement. Social Worker Courtney Eichelberger testified in her deposition that she walked down the N line daily, but the security logs show that she only appeared on the N line once during the week and a half she worked at EBRPP when Mr. Fano was there. Dr. Kissinger, the mental health director for CorrectHealth, visited EBRPP and when he toured the N and M lines, he was aware of the placement of patients on suicide watch in those housing areas. When asked whether he had concerns about suicide risks for patient in those cells he replied "I don't recall having any thoughts about that" and when asked whether he ever had a conversation about the physical elements of the cells he replied "I don't know." When deposed in this case, the owner of CorrectHealth, Dr. Carlo Musso reported that he was unaware of the rate of death of patients at EBRPP and that regarding the comparison of the number of deaths in EBRPP reflecting a higher rate than is publicly reported by the Department of Justice for jail deaths nationally, he replied "I don't have an opinion on that nor have I been able to independently verify that." This is a stunning admission from the person who leads the organization that sought out and was granted responsibility for providing health care in EBRPP.

A review of other deaths in EPRBB raises concerns that many of the contributors to Mr. Fano's death represent systematic failings that have also contributed to other deaths.[8] In particular, review of the very limited death reviews conducted regarding the homicide of Mr. Tyrin Colbert in 2016, the death of Mr. Brian Ducre in 2016 and the suicide of Mr. Rickey Whatley five months after the death of Mr. Fano. In the case of Mr. Colbert's

[8] I understand that CorrectHealth claimed to have performed mortality reviews on the deaths at EBRPP that occurred on their watch. This report is preliminary in the sense that it was written without the benefit of those documents.

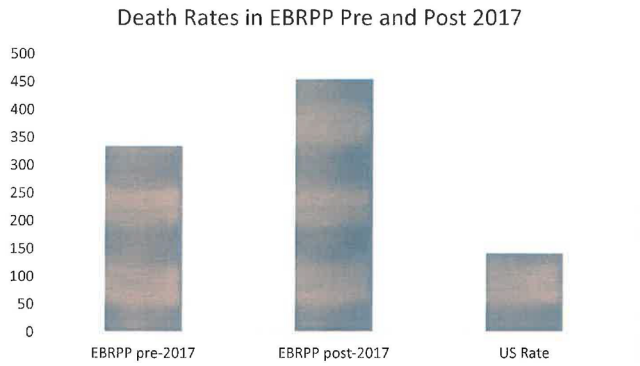
homicide, other detainees told investigators that they heard the altercation between Mr. Colbert and his cellmate, but no security intervention occurred and Mr. Colbert was only discovered after being killed by his cellmate. This lack of basic surveillance and oversight of a cell housing area represents a serious breach in basic correctional standards, especially since Mr. Colbert had recently been removed from suicide watch, as had Mr. Fano.

In the case of Mr. Ducre, who died of homicide in EBRPP, he was well-documented to have sustained numerous injuries shortly before his death including facial and head trauma. Mr. Ducre was also documented as acting erratically including having possible hallucinations and he had a history of schizophrenia. The security report into his death notes that he was "placed on Lockdown for observation." This represents a gross failure on the part of security and health staff by placing a vulnerable patient into a solitary confinement setting (N line), where is it clear he would be left alone in a cell, far from medical monitoring. In the case of Mr. Whatley, he was also held in solitary confinement and hanged himself, five months after the suicide of Mr. Fano and six months after CorrectHealth assumed responsibility for care.

The overall rate of death in EBRPP appears to be over twice the national average and ongoing the practices of CorrectHealth and EBRPP are clearly increasing the likelihood of death for detainees. Review of the number of deaths in EBRPP indicate that 25 deaths occurred in the 5 years before the CorrectHealth transition, while 17 deaths have occurred in the 2 ½ years since the transition.[9] This would translate to annual rates of death

[9] Calculations based on average daily population of 1,500 people from 2012 through July 2019. Sources include 1) Farris, S. and Armstrong, A., Dying in East Baton Rouge Parish Prison (July 2018) available at https://promiseofjustice.org/wp-content/uploads/2019/07/Dying-in-East-Baton-Rouge-Parish-Prison-Final.pdf and 2) Walter Smith deposition, Exhibit 2 (monthly statistical reports created by CorrectHealth) and 3) Mortality in Local Jails 2000-2014), U.S. Department of Justice, Bureau of Justice Statistics., available at https://www.bjs.gov/content/pub/pdf/mlj0014_sum.pdf.

of 333 per 100,000 inmates before the transition and 453 per 100,000 after the transition. By comparison, the national average rate of death was 140 per 100,000 jail inmates based on U.S. Department of Justice reporting (see Table below).



CorrectHealth staff and leadership acknowledge the use of solitary confinement as a primary response to mental health crises, despite this practice being discredited and associated with death. In addition, the ongoing short-staffing of CorrectHealth in this facility results in a lack of adequate care even when people are able to have an encounter with a health professional. Nowhere is this more apparent than the rushed and inadequate care provided to vulnerable patients held on the N and M lines in solitary confinement.

5. Taken together, these reports from staff who worked before and after the transition to CorrectHealth show that Mr. Fano was provided care in a setting that failed to make meaningful improvements despite changing the health service provider and where little effort was put into keeping close surveillance on high risk patients. These failures represent systemic and ongoing breaches in the standard of care that significantly increase the risk of death for patients in EBRPP and display an unwillingness or inability of CorrectHealth to make meaningful improvements.
6. My overall assessment is that Mr. Fano's death was preventable. My medical opinion is that the health service made substantial contributions to his death by ignoring his history of serious mental illness, ignoring his obvious signs of serious mental illness and stated

need for higher levels of care, combined with the direction by health and security staff that he be placed into solitary confinement in a unit lacking basic suicide prevention measures and left there for over three (3), made substantial contributions to his death.

Attachment B

Dr. Homer D. Venters

10 ½ Jefferson St., Port Washington, NY, 11050
hventers@gmail.com, Phone: 646-734-5994

HEALTH ADMINISTRATOR PHYSICIAN EPIDEMIOLOGIST

Professional Profile

- International leader in provision and improvement of health services to patients with criminal justice involvement.
- Innovator in linking care of patients with justice involvement to health systems and Medicaid coverage.
- Successful implementer of nations' first electronic health record, performance dashboards and health information exchange among detained pre-trial patients.
- Award winning epidemiologist focused on the intersection of health, criminal justice and human rights in the United States and developing nations.
- Human rights leader with experience using forensic science, epidemiology and public health methods to prevent and document human rights abuses.

Professional Experience

President, Community Oriented Correctional Health Services (COCHS), Starting 1/1/20.

- Oversee all aspects of COCHS work including technical assistance, policy reform regarding correctional health.
- Lead new initiatives regarding suicide prevention and alternatives t solitary confinement in jail and prison settings.
- Serve as primary point of contact with COCHS board, press, stakeholders and funders regarding COCHS work.

Senior Health and Justice Fellow, Community Oriented Correctional Health Services (COCHS), Starting 11/1/18.

- Lead COCHS efforts to expand Medicaid waivers for funding of care for detained persons relating to Substance Use and Hepatitis C.
- Develop and implement COCHS strategy for promoting non-profit models of diversion and correctional health care.

Medical/Forensic Expert, 3/2016-present

- Provide expert input, review and testimony regarding health care, quality improvement, electronic health records and data analysis in detention settings.

Director of Programs, Physicians for Human Rights, 3/16-11/18.

- Lead medical forensic documentation efforts of mass crimes against Rohingya and Yazidi people.
- Initiate vicarious trauma program.
- Expand forensic documentation of mass killings and war crimes.
- Develop and support sexual violence capacity development with physicians, nurses and judges.
- Expand documentation of attacks against health staff and facilities in Syria and Yemen.

Chief Medical Officer/Assistant Vice President, Correctional Health Services, NYC Health and Hospitals Corporation 8/15-3/17.

- Transitioned entire clinical service (1,400 staff) from a for-profit staffing company model to a new division within NYC H + H.
- Developed new models of mental health and substance abuse care that significantly lowered morbidity and other adverse events.
- Connected patients to local health systems, DSRIP and health homes using approximately $5 million in external funding (grants available on request).
- Reduced overall mortality in the nation's second largest jail system.
- Increased operating budget from $140 million to $160 million.
- Implemented nation's first patient experience, provider engagement and racial disparities programs for correctional health.

Assistant Commissioner, Correctional Health Services, New York Department of Health and Mental Hygiene, 6/11-8/15.

- Implemented nation's first electronic medical record and health information exchange for 1,400 staff and 75,000 patients in a jail.
- Developed bilateral agreements and programs with local health homes to identify incarcerated patients and coordinate care.
- Increased operating budget of health service from $115 million to $140 million.
- Established surveillance systems for injuries, sexual assault and mental health that drove new program development and received American Public Health Association Paper of the Year 2014.
- Personally care for and reported on over 100 patients injured during violent encounters with jail security staff.

Medical Director, Correctional Health Services, New York Department of Health and Mental Hygiene, 1/10-6/11.

- Directed all aspects of medical care for 75,000 patients annually in 12 jails, including specialty, dental, primary care and emergency response.
- Direct all aspects of response to infectious outbreaks of H1N1, Legionella, Clostridium Difficile.
- Developed new protocols to identify and report on injuries and sexual assault among patients.

Deputy Medical Director, Correctional Health Services, New York Department of Health and Mental Hygiene, 11/08-12/09.

- Developed training program with Montefiore Social internal medicine residency program.
- Directed and delivered health services in 2 jails.

Clinical Attending Physician, Bellevue/NYU Clinic for Survivors of Torture, 10/07-12/11.

Clinical Attending Physician, Montefiore Medical Center Bronx NY, Adult Medicine, 1/08-11/09.

Education and Training

Fellow, Public Health Research, New York University 2007-2009. MS 6/2009
Projects: Health care for detained immigrants, Health Status of African immigrants in NYC.

Resident, Social Internal Medicine, Montefiore Medical Center/Albert Einstein University7/2004- 5/2007.
M.D., University of Illinois, Urbana, 12/2003.
M.S. Biology, University of Illinois, Urbana, 6/03.
B.A. International Relations, Tufts University, Medford, MA, 1989.

Academic Appointments, Licensure

Clinical Associate Professor, New York University College of Global Public Health, 5/18-present.

Clinical Instructor, New York University Langone School of Medicine, 2007-2018.
M.D. New York (2007-present).

Peer Reviewed Publications

Venters H. Notions from Kavanaugh hearings contradict medical facts. *Lancet.* 10/5/18.

Taylor GP, Castro I, Rebergen C, Rycroft M, Nuwayhid I, Rubenstein L, Tarakji A, Modirzadeh N, **Venters H**, Jabbour S. Protecting health care in armed conflict: action towards accountability. *Lancet.* 4/14/18.

Katyal M, Leibowitz R, **Venters H**. IGRA-Based Screening for Latent Tuberculosis Infection in Persons Newly Incarcerated in New York City Jails. *J Correct Health Care.* 2018 4/18.

Harocopos A, Allen B, Glowa-Kollisch S, **Venters H**, Paone D, Macdonald R. The Rikers Island Hot Spotters: Exploring the Needs of the Most Frequently Incarcerated.
J Health Care Poor Underserved. 4/28/17.

MacDonald R, Akiyama MJ, Kopolow A, Rosner Z, McGahee W, Joseph R, Jaffer M, **Venters H**. Feasibility of Treating Hepatitis C in a Transient Jail Population.
Open Forum Infect Dis. 7/7/18.

Siegler A, Kaba F, MacDonald R, **Venters H**. Head Trauma in Jail and Implications for Chronic Traumatic Encephalopathy. *J Health Care Poor and Underserved.* In Press (May 2017).

Ford E, Kim S, **Venters H**. Sexual abuse and injury during incarceration reveal the need for re-entry trauma screening. *Lancet.* 4/8/18.

Alex B, Weiss DB, Kaba F, Rosner Z, Lee D, Lim S, **Venters H,** MacDonald R. Death After Jail Release. *J Correct Health Care.* 1/17.

Akiyama MJ, Kaba F, Rosner Z, Alper H, Kopolow A, Litwin AH, **Venters H**, MacDonald R. Correlates of Hepatitis C Virus Infection in the Targeted Testing Program of the New York City Jail System. *Public Health Rep.* 1/17.

Kalra R, Kollisch SG, MacDonald R, Dickey N, Rosner Z, **Venters H**. Staff Satisfaction, Ethical Concerns, and Burnout in the New York City Jail Health System. *J Correct Health Care*. 2016 Oct;22(4):383-392.

Venters H. A Three-Dimensional Action Plan to Raise the Quality of Care of US Correctional Health and Promote Alternatives to Incarceration. *Am J Public Health*. April 2016.104.

Glowa-Kollisch S, Kaba F, Waters A, Leung YJ, Ford E, **Venters H**. From Punishment to Treatment: The "Clinical Alternative to Punitive Segregation" (CAPS) Program in New York City Jails. *Int J Env Res Public Health*. 2016. 13(2),182.

Jaffer M, Ayad J, Tungol JG, MacDonald R, Dickey N, Venters H. Improving Transgender Healthcare in the New York City Correctional System. *LGBT Health*. 2016 1/8/16.

Granski M, Keller A, Venters H. Death Rates among Detained Immigrants in the United States. *Int J Env Res Public Health*. 2015. 11/10/15.

Michelle Martelle, Benjamin Farber, Richard Stazesky, Nathaniel Dickey, Amanda Parsons, **Homer Venters**. Meaningful Use of an Electronic Health Record in the NYC Jail System. *Am J Public Health*. 2015. 8/12/15.

Fatos Kaba, Angela Solimo, Jasmine Graves, Sarah Glowa-Kollisch, Allison Vise, Ross MacDonald, Anthony Waters, Zachary Rosner, Nathaniel Dickey, Sonia Angell, **Homer Venters**. Disparities in Mental Health Referral and Diagnosis in the NYC Jail Mental Health Service. *Am J Public Health*. 2015. 8/12/15.

Ross MacDonald, Fatos Kaba, Zachary Rosner, Alison Vise, Michelle Skerker, David Weiss, Michelle Brittner, Nathaniel Dickey, **Homer Venters**. The Rikers Island Hot Spotters. *Am J Public Health*. 2015. 9/17/15.

Selling Molly Skerker, Nathaniel Dickey, Dana Schonberg, Ross MacDonald, **Homer Venters**. Improving Antenatal Care for Incarcerated Women: fulfilling the promise of the Sustainable Development Goals. *Bulletin of the World Health Organization*.2015.

Jasmine Graves, Jessica Steele, Fatos Kaba, Cassandra Ramdath, Zachary Rosner, Ross MacDonald, Nathanial Dickey, **Homer Venters** Traumatic Brain Injury and Structural Violence among Adolescent males in the NYC Jail System *J Health Care Poor Underserved.* 2015;26(2):345-57.

Glowa-Kollisch S, Graves J, Dickey N, MacDonald R, Rosner Z, Waters A, **Venters H**. Data-Driven Human Rights: Using Dual Loyalty Trainings to Promote the Care of Vulnerable Patients in Jail. *Health and Human Rights*. Online ahead of print, 3/12/15.

Teixeira PA[1], Jordan AO, Zaller N, Shah D, **Venters H**. Health Outcomes for HIV-Infected Persons Released From the New York City Jail System With a Transitional Care-Coordination Plan. 2014. *Am J Public Health*. 2014 Dec 18.

Selling D, Lee D, Solimo A, **Venters H.** A Road Not Taken: Substance Abuse Programming in the New York City Jail System. *J Correct Health Care.* 2014 Nov 17.

Glowa-Kollisch S, Lim S, Summers C, Cohen L, Selling D, **Venters H**. Beyond the Bridge: Evaluating a Novel Mental Health Program in the New York City Jail System. *Am J Public Health*. 2014 Sep 11.

Glowa-Kollisch S, Andrade K, Stazesky R, Teixeira P, Kaba F, MacDonald R, Rosner Z, Selling D, Parsons A, **Venters H**. Data-Driven Human Rights: Using the Electronic Health Record to Promote Human Rights in Jail. *Health and Human Rights*. 2014. Vol 16 (1): 157-165.

MacDonald R, Rosner Z, **Venters H**. Case series of exercise-induced rhabdomyolysis in the New York City Jail System. *Am J Emerg Med*. 2014. Vol 32(5): 446-7.

Bechelli M, Caudy M, Gardner T, Huber A, Mancuso D, Samuels P, Shah T, **Venters H.** Case Studies from Three States: Breaking Down Silos Between Health Care and Criminal Justice. *Health Affairs*. 2014. Vol. 3. 33(3):474-81.

Selling D, Solimo A, Lee D, Horne K, Panove E, **Venters H**. Surveillance of suicidal and non-suicidal self-injury in the new York city jail system. *J Correct Health Care*. 2014. Apr:20(2).

Kaba F, Diamond P, Haque A, MacDonald R, **Venters H**. Traumatic Brain Injury Among Newly Admitted Adolescents in the New York City Jail System. *J Adolesc Health*. 2014. Vol 54(5): 615-7.

Monga P, Keller A, **Venters H**. Prevention and Punishment: Barriers to accessing health services for undocumented immigrants in the United States. *LAWS*. 2014. 3(1).

Kaba F, Lewsi A, Glowa-Kollisch S, Hadler J, Lee D, Alper H, Selling D, MacDonald R, Solimo A, Parsons A, **Venters H**. Solitary Confinement and Risk of Self-Harm Among Jail Inmates. *Amer J Public Health*. 2014. Vol 104(3):442-7.

MacDonald R, Parsons A, **Venters H.** The Triple Aims of Correctional Health: Patient safety, Population Health and Human Rights. *Journal of Health Care for the Poor and Underserved*. 2013. 24(3).

Parvez FM, Katyal M, Alper H, Leibowitz R, **Venters H.** Female sex workers incarcerated in New York City jails: prevalence of sexually transmitted infections and associated risk behaviors. *Sexually Transmitted Infections*. 89:280-284. 2013.

Brittain J, Axelrod G, **Venters H.** Deaths in New York City Jails: 2001 – 2009. *Am J Public Health*. 2013 103:4.

Jordan AO, Cohen LR, Harriman G, Teixeira PA, Cruzado-Quinones J, **Venters H.** Transitional Care Coordination in New York City Jails: Facilitating Linkages to Care for People with HIV Returning Home from Rikers Island. *AIDS Behav. Nov.* 2012.

Jaffer M, Kimura C, **Venters H.** Improving medical care for patients with HIV in New York City jails. *J Correct Health Care*. 2012 Jul;18(3):246-50.

Ludwig A, Parsons, A, Cohen, L, **Venters H.** Injury Surveillance in the NYC Jail System, *Am J Public Health* 2012 Jun;102(6).

Venters H, Keller, AS. *Psychiatric Services*. (2012) Diversion of Mentally Ill Patients from Court-ordered care to Immigration Detention. Epub. 4/2012.

Venters H, Gany, F. *Journal of Immigrant and Minority Health* (2011) Mental Health Concerns Among African Immigrants. 13(4): 795-7.

Venters H, Foote M, Keller AS. *Journal of Immigrant and Minority Health.* (2010) Medical Advocacy on Behalf of Detained Immigrants. 13(3): 625-8.

Venters H, McNeely J, Keller AS. *Health and Human Rights.* (2010) HIV Screening and Care for Immigration Detainees. 11(2) 91-102.

Venters H, Keller AS. *Journal of Health Care for the Poor and Underserved*. (2009) The Immigration Detention Health Plan: An Acute Care Model for a Chronic Care Population. 20:951-957.

Venters H, Gany, F. *Journal of Immigrant and Minority Health* (2009) African Immigrant Health. 4/4/09.

Venters H, Dasch-Goldberg D, Rasmussen A, Keller AS, *Human Rights Quarterly* (2009) Into the Abyss: Mortality and Morbidity among Detained Immigrant. 31 (2) 474-491.

Venters H, *The Lancet* (2008) Who is Jack Bauer? 372 (9653).

Venters H, Lainer-Vos J, Razvi A, Crawford J, Shaf'on Venable P, Drucker EM, *Am J Public Health* (2008) Bringing Health Care Advocacy to a Public Defender's Office. 98 (11).

Venters H, Razvi AM, Tobia MS, Drucker E. *Harm Reduct J.* (2006) The case of Scott Ortiz: a clash between criminal justice and public health. Harm Reduct J. 3:21

Cloez-Tayarani I, Petit-Bertron AF, **Venters HD**, Cavaillon JM (2003) *Internat. Immunol.* Differential effect of serotonin on cytokine production in lipopolysaccharide-stimulated human peripheral blood mononuclear cells.15,1-8.

Strle K, Zhou JH, Broussard SR, **Venters HD**, Johnson RW, Freund GG, Dantzer R, Kelley KW, (2002) *J. Neuroimmunol.* IL-10 promotes survival of microglia without activating Akt. 122, 9-19.

Venters HD, Broussard SR, Zhou JH, Bluthe RM, Freund GG, Johnson RW, Dantzer R, Kelley KW, (2001) *J. Neuroimmunol.* Tumor necrosis factor(alpha) and insulin-like growth factor-I in the brain: is the whole greater than the sum of its parts? 119, 151-65.

Venters HD, Dantzer R, Kelley KW, (2000) *Ann. N. Y. Acad. Sci.* Tumor necrosis factor-alpha

induces neuronal death by silencing survival signals generated by the type I insulin-like growth factor receptor. 917, 210-20.

Venters HD, Dantzer R, Kelley KW, (2000) *Trends. Neurosci.* A new concept in neurodegeneration: TNFalpha is a silencer of survival signals. 23, 175-80.

Venters HD, Tang Q, Liu Q, VanHoy RW, Dantzer R, Kelley KW, (1999) *Proc. Natl. Acad. Sci. USA.* A new mechanism of neurodegeneration: A proinflammatory cytokine inhibits receptor signaling by a survival peptide, 96, 9879-9884.

Venters HD, Ala TA, Frey WH 2nd , (1998) Inhibition of antagonist binding to human brain muscarinic receptor by vanadium compounds. *Recept. Signal. Transduct.* 7, 137-142.

Venters HD, Tang Q, Liu Q, VanHoy RW, Dantzer R, Kelley KW, (1999) *Proc. Natl. Acad. Sci. USA.* A new mechanism of neurodegeneration: A proinflammatory cytokine inhibits receptor signaling by a survival peptide, 96, 9879-9884.

Venters HD, Ala TA, Frey WH 2nd , (1998) Inhibition of antagonist binding to human brain muscarinic receptor by vanadium compounds. *Recept. Signal. Transduct.* 7, 137-142**.**

Venters HD, Bonilla LE, Jensen T, Garner HP, Bordayo EZ, Najarian MM, Ala TA, Mason RP, Frey WH 2nd, (1997) Heme from Alzheimer's brain inhibits muscarinic receptor binding via thiyl radical generation. *Brain. Res.* 764, 93-100.

Kjome JR, Swenson KA, Johnson MN, Bordayo EZ, Anderson LE, Klevan LC, Fraticelli AI, Aldrich SL, Fawcett JR, **Venters HD**, Ala TA, Frey WH 2nd (1997) Inhibition of antagonist and agonist binding to the human brain muscarinic receptor by arachidonic acid. *J. Mol. Neurosci.* 10, 209-217.

Honors and Presentations (past 10 years)

Oral Presentation, Dual loyalty and other human rights concerns for physicians in jails an prisons. Association of Correctional Physicians, Annual meeting. 10/16, Las Vegas.

Oral Presentation, Clinical Alternatives to Punitive Segregation: Reducing self-harm for incarcerated patients with mental illness. American Public Health Association Annual Meeting, November 2015, Chicago IL.

Oral Presentation, Analysis of Deaths in ICE Custody over 10 Years . American Public Health Association Annual Meeting, November 2015, Chicago IL.

Oral Presentation, Medication Assisted Therapies for Opioid Dependence in the New York City Jail System. American Public Health Association Annual Meeting, November 2015, Chicago IL.

Oral Presentation, Pathologizing Normal Human Behavior: Violence and Solitary Confinement in an Urban Jail. American Public Health Association Annual Meeting, November 2014, New Orleans, LA.

Training, International Committee of the Red Cross and Red Crescent, Medical Director meeting

10/15, Presentation on Human Rights and dual loyalty in correctional health.

Paper of the Year, American Public Health Association. 2014. (Kaba F, Lewis A, Glowa-Kollisch S, Hadler J, Lee D, Alper H, Selling D, MacDonald R, Solimo A, Parsons A, Venters H. Solitary Confinement and Risk of Self-Harm Among Jail Inmates. *Amer J Public Health*. 2014. Vol 104(3):442-7.)

Oral Presentation, Pathologizing Normal Human Behavior: Violence and Solitary Confinement in an Urban Jail. *American Public Health Association* Annual Meeting, New Orleans LA, 2014.

Oral Presentation, Human rights at Rikers: Dual loyalty among jail health staff. American Public Health Association Annual Meeting, New Orleans LA, 2014.

Poster Presentation, Mental Health Training for Immigration Judges. American Public Health Association Annual Meeting, New Orleans LA, 2014.

Distinguished Service Award; Managerial Excellence. Division of Health Care Access and Improvement, NYC DOHMH. 2013.

Oral Presentation, Solitary confinement in the ICE detention system. American Public Health Association Annual Meeting, Boston MA, 2013.

Oral Presentation, Self-harm and solitary confinement in the NYC jail system. American Public Health Association Annual Meeting, Boston MA, 2013.

Oral Presentation, Implementing a human rights practice of medicine inside New York City jails. American Public Health Association Annual Meeting, Boston MA, 2013.

Poster Presentation, Human Rights on Rikers: integrating a human rights-based framework for healthcare into NYC's jail system. *American Public Health Association* Annual Meeting, Boston MA, 2013.

Poster Presentation, Improving correctional health care: health information exchange and the affordable care act. *American Public Health Association* Annual Meeting, Boston MA, 2013.

Oral Presentation, Management of Infectious Disease Outbreaks in a Large Jail System. American Public Health Association Annual Meeting, Washington DC, 2011.

Oral Presentation, Diversion of Patients from Court Ordered Mental Health Treatment to Immigration Detention. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Initiation of Antiretroviral Therapy for Newly Diagnosed HIV Patients in the NYC Jail System. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Medical Case Management in Jail Mental Health Units. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Injury Surveillance in New York City Jails. *American Public Health*

Association Annual Meeting, Washington DC, 2011.

Oral Presentation, Ensuring Adequate Medical Care for Detained Immigrants. Venters H, Keller A, American Public Health Association Annual Meeting, Denver, CO, 2010.

Oral Presentation, HIV Testing in NYC Correctional Facilities. Venters H and Jaffer M, *American Public Health Association,* Annual Meeting, Denver, CO, 2010.

Oral Presentation, Medical Concerns for Detained Immigrants. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Oral Presentation, Growth of Immigration Detention Around the Globe. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Oral Presentation, Role of Hospital Ethics Boards in the Care of Immigration Detainees. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Oral Presentation, Health Law and Immigration Detainees. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Bro Bono Advocacy Award, Advocacy on behalf of detained immigrants. Legal Aid Society of New York, October 2009.

Oral Presentation, Deaths of immigrants detained by Immigration and Customs Enforcement. Venters H, Rasmussen A, Keller A, *American Public Health Association* Annual Meeting, San Diego CA, October 2008.

Poster Presentation, Death of a detained immigrant with AIDS after withholding of prophylactic Dapsone. Venters H, Rasmussen A, Keller A, *Society of General Internal Medicine* Annual Meeting, Pittsburgh PA, April 2008.

Poster Presentation, Tuberculosis screening among immigrants in New York City reveals higher rates of positive tuberculosis tests and less health insurance among African immigrants. *Society of General Internal Medicine* Annual Meeting, Pittsburgh PA, April 2008.

Daniel Leicht Award for Achievement in Social Medicine, Montefiore Medical Center, Department of Family and Social Medicine, 2007.

Poster Presentation, Case Findings of Recent Arestees. Venters H, Deluca J, Drucker E. *Society of General Internal Medicine* Annual Meeting, Toronto Canada, April 2007.

Poster Presentation, Bringing Primary Care to Legal Aid in the Bronx. Venters H, Deluca J, Drucker E. *Society of General Internal Medicine* Annual Meeting, Los Angeles CA, April 2006.

Poster Presentation, A Missed Opportunity, Diagnosing Multiple Myeloma in the Elderly Hospital Patient. Venters H, Green E., *Society of General Internal Medicine* Annual Meeting, New Orleans LA, April 2005.

Grants: Individual

Co-Principal Investigator, Immigration Detention Health Resource Project (IDHR). Langeloth Foundation (Project 1917). January 1 2013-January 31 2017 (initial grant 2011-2013). Total grant amount $300,611.

Principal Investigator, Investigation of testosterone levels, depression and mental status as these variables associate with HIV dementia. Carle Hospital, Urbana Illinois, total Costs $1,500 (2003).

Principal Investigator, Pro-Inflammatory Cytokine Expression during Pediatric HIV-Encephalopathy in Togo, West Africa. Elizabeth Glaser Pediatric AIDS Research Foundation, total Costs $5,000 (2000-2001).

Grants: Program

Ryan White Part A - Prison Release Services (PRS). From HHS/HRSA to Correctional Health Services (NYC DOHMH), 3/1/16-2/28/17 (Renewed since 2007). Annual budget $ 2.7 million.

Ryan White Part A - Early Intervention Services- Priority Population Testing. From HHS/HRSA to Correctional Health Services (NYC DOHMH), 3/1/16-2/28/18 (Renewed since 2013). Annual budget $250,000.

Comprehensive HIV Prevention. From HHS to Correctional Health Services (NYC DOHMH), 1/1/16-12/31/16. Annual budget $500,000.

HIV/AIDS Initiative for Minority Men. From HHS Office of Minority Health to Correctional Health Services (NYC DOHMH), 9/30/14-8/31/17. Annual budget $375,000.

SPNS Workforce Initiative, From HRSA SPNS to Correctional Health Services (NYC DOHMH), 8/1/14-7/31/18. Annual budget $280,000.

SPNS Culturally Appropriate Interventions. From HRSA SPNS to Correctional Health Services (NYC DOHMH), 9/1/13-8/31/18. Annual budget $290,000.

Residential substance abuse treatment. From New York State Division of Criminal Justice Services to Correctional Health Services (NYC DOHMH), 1/1/11-12/31/17. Annual budget $175,000.

Community Action for Pre-Natal Care (CAPC). From NY State Department of Health AIDS Institute to Correctional Health Services (NYC DOHMH), 1/1/05-12/31/10. Annual budget $290,000.

Point of Service Testing. From MAC/AIDS, Elton John and Robin Hood Foundations to Correctional Health Services (NYC DOHMH), 11/1/09-10/31/12. Annual budget $100,000.

Mental Health Collaboration Grant. From USDOJ to Correctional Health Services (NYC DOHMH), 1/1/11-9/30/13. Annual budget $250,000.

Teaching

Instructor, Health in Prisons Course, Bloomberg School of Public Health, Johns Hopkins University, April 2019, June 2015, June 2014.

Instructor, Albert Einstein College of Medicine/Montefiore Social Medicine Program Yearly lectures on Data-driven human rights, 2007-present.

Other Health & Human Rights Activities

DIGNITY Danish Institute Against Torture, Symposium with Egyptian correctional health staff regarding dual loyalty and data-driven human rights. Cairo Egypt, September 20-23, 2014.

Doctors of the World, Physician evaluating survivors of torture, writing affidavits for asylum hearings, with testimony as needed, 7/2005-present.

United States Peace Corps, **Guinea Worm Educator,** Togo West Africa, June 1990- December 1991.

-*Primary Project;* Draconculiasis Eradication. Activities included assessing levels of infection in 8 rural villages and giving prevention presentations to mothers in Ewe and French

-*Secondary Project;* Malaria Prevention.

Books

Venters H. *Life and Death in Rikers Island.* Johns Hopkins University Press. 2/19.

Chapters in Books

Venters H. Mythbusting Solitary Confinement. In *Solitary Confinement: History, Effects, and Pathways to Reform.* Editors: Jules Lobel and Peter Scharff Smith. University of Pittsburgh Press. Expected 2019.

MacDonald R. and **Venters H.** Correctional Health and Decarceration. In Decarceration. Ernest Drucker, New Press, 2017.

Venters, H.D. Jr., R. Dantzer, G.G. Freund and K.W. Kelley. 2001. Growth hormone and insulin-like growth factor as cytokines in the immune system. *In* R. Ader, D. L. Felten and N. Cohen (Eds.) *Psychoneuroimmunology*. Third Edition. Academic Press, New York, New York. pp 339-362.

Testimony and Op-Ed Columns

New York State Assembly Committee on Correction with the Committee on Mental Health: Regarding Access to Medication Assisted Treatment in Prisons and in Correctional Settings. November 15, 2018. NY, NY.

Venters HD, New York Advisory Committee to the U.S. Commission on Civil Rights: Regarding the use of solitary confinement for juveniles in New York. July 10, 2014. NY NY.

New York State Assembly Committee on Correction with the Committee on Mental Health: Regarding Mental Illness in Correctional Settings. November 13, 2014. Albany NY.

Venters HD, New York State Assembly Committee on Correction with the Committee on Mental Health: Regarding Mental Illness in Correctional Settings. November 13, 2014. Albany NY.

Venters HD and Keller AS, The Health of Immigrant Detainees. Boston Globe, April 11, 2009.

Venters HD, U.S. House of Representatives, House Judiciary Committee's Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law: Hearing on Problems with Immigration Detainee Medical Care, June 4, 2008.

Membership in Professional Organizations

American Public Health Association

Foreign Language Proficiency

French Proficient
Ewe Conversant

Prior Testimony and Deposition

Benjamin v. Horn, 75 Civ. 3073 (HB) (S.D.N.Y.) as expert for defendants, 2015

Rodgers v. Martin 2:16-cv-00216 (U.S.D.C. N.D.Tx) as expert for plaintiffs, 10/19/17

Fikes v. Abernathy, 2017 7:16-cv-00843-LSC (U.S.D.C. N.D.AL) as expert for plaintiffs 10/30/17

Fernandez v. City of New York, 17-CV-02431 (GHW)(SN) (S.D.NY) as defendant in role as City Employee 4/10/18.

Charleston v. Corizon Health INC, 17-3039 (U.S.D.C. E.D. PA) as expert for plaintiffs 4/20/18.

Gambler v. Santa Fe County, 1:17-cv-00617 (WJ/KK) as expert for plaintiffs 7/23/18.

Hammonds v. Dekalb County AL, CASE NO.: 4:16-cv-01558-KOB as expert for plaintiffs 11/30/2018.

Mathiason v. Rio Arriba County NM, No. D-117-CV-2007-00054, as expert for plaintiff 2/7/19.

Lewis v. Gautreaux, et al., No. 17-656-JWD-RLB (M.D. La. 2017), as expert for the plaintiff, 6/25 and 7/1, 2019

Fee Schedule

Case review, reports, testimony $400/hour.

Statement of Charges:

Initial review of documents and preliminary draft (6/12/19); 7 hours, $2,800.

Review of additional documents and report finalization (12/27/19); 14 hours, $5,600.

EXHIBIT B

Jeffrey A. Schwartz, Ph.D.
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Zavala v. City of Baton Rouge/Parish East Baton Rouge, et al.

Preliminary Report

January 7, 2020

I. Overview

In 2015, the Warden of the East Baton Rouge Parish Prison ("EBR"), the Sheriff of East Baton Rouge and the Sheriff's attorney addressed the City of Baton Rouge/Parish of East Baton Rouge Metropolitan Council ("Council") and testified that EBR was an old facility in very poor condition and that in particular, it could not safely incarcerate mental health inmates. The Chief Administrative Officer for the Parish and City concurred and told the Council that the situation was an emergency and, prophetically, that increased funding for EBR was a life and death matter for mentally ill inmates there.

The Council hired a health services consulting firm to do a comprehensive analysis of the healthcare and mental health care facilities and operations at EBR. That consulting group, Health Management Associates ("HMA") presented a detailed report to the Council in mid 2016 that corroborated the earlier public testimony about EBR. The report specifically found that EBR facilities, services and operations were inadequate or inappropriate for mental health inmates. Parish officials, EBR managers and HMA were in agreement that the largest barrier at EBR to housing mental health inmates safely was the lack of a dedicated mental health housing unit and inadequate staffing. Rather than take steps to implement HMA's recommendations, the Parish and EBR did nothing more substantial than to privatize the provision of health care services and marginally increase the budget in response to these warnings and continued to incarcerate mentally ill inmates, including the severely mentally ill, at EBR, essentially under the same conditions.

Jonathon Fano was a small, slight Hispanic male with a history of serious mental illness. On October 30, 2016, he was arrested in downtown Baton Rouge, Louisiana partially naked, hallucinating and delusional and taken to EBR. There, his history and condition were ignored at intake and he was put in general population where he attempted suicide within hours. Rather than providing treatment for Mr. Fano, EBR sentenced him to 20 days punitive segregation for his suicide attempt and then left him in segregation housing, largely without treatment, programs or review for three months, until his suicide. Inmates complained to the segregation staff and to the medical/mental health staff that Mr. Fano was acutely mentally ill and that he was constantly asking for a razor so that he could kill himself.

In late January, 2017, Jonathon Fano tried to commit suicide by hanging but the literature broke and he fell with a loud noise, alerting other inmates to his suicide attempt. They again notified staff that he needed help but the case record provides no indication of any staff response. A few days later, on February 2, 2017 Mr. Fano successfully committed suicide by hanging himself in his cell. His tragic death was predictable and almost certainly preventable.

Mr. Fano's history at EBR prior to his suicide is more than disturbing. He was kept in segregation housing for all but two days of his more than three months at EBR. This alone was a major violation of accepted correctional standards. He was allowed out of the cell for 15 minutes a day, four days a week and 30 minutes a day, three days a week. He had no access to programs. After his initial phone call home immediately after his arrest, he was unable to successfully place a call to his loving and supportive family until Christmas Day, 2016. In spite of inmate warnings, neither security staff nor medical/mental health staff noticed when Mr. Fano did not come out of his cell for his hall times, when he was actively hallucinating or, most importantly, when he was asking for a razor to kill himself, nor did they act when fellow inmates informed them of these behaviors. EBR's psychiatrist saw Mr. Fano once after his initial suicide attempt and did not see him again until January 18, 2017, when he decided Mr. Fano wasn't seriously mentally ill and ordered his antipsychotic medication be stopped in a week's time. A few days after his medication was discontinued, Mr. Fano committed suicide.

II. Introduction and Background

My name is Jeffrey A. Schwartz, Ph.D., and my office is at 1610 La Pradera Drive in Campbell, California. I am the president of Law Enforcement Training and Research Associates, Inc. (LETRA), a criminal justice training and consulting organization that has had offices in the San Francisco Bay area since its incorporation in June, 1972. I have worked full time with law enforcement and correctional agencies across the United States and Canada for over 35 years, both as LETRA's president and as a private consultant. The largest proportion of my work for the last 20 years has been working with prisons and jails, assisting them in applying national corrections standards to their operations for, among other things, preventing foreseeable suicides in those facilities. I have worked with more than 40 of the 50 state departments of corrections and with small, medium and large jails and local departments of corrections. During my career I have worked with and toured literally hundreds of prisons and jails. Particularly in my work conducting operational reviews of jails and prisons, I have reviewed inmate access to health care and related issues, such as the inmate grievance system and the nature of medical staff-inmate interactions, on many occasions. I have also specifically reviewed the training of correctional staff on medical issues and the medical staff compliance with contract issues, both in my expert witness work and my consulting activities.

I have served as an expert witness for both Plaintiffs and Defendants on more than 15 inmate suicide cases. I have written or co-written chapters in training texts for correctional staff on suicide and suicide prevention in jails and prisons. I have spent hundreds of hours training and certifying correctional staff as instructors for the suicide prevention training that I developed. Additionally, analyses of suicide prevention policies, practices and facility "hardening" against suicide, have been a major component of many of the operational reviews of jails and prisons I have conducted.

I am currently a Federal Court Monitor of a consent decree on conditions in the Los Angeles Jails. I am also a Federal Court Monitor for a consent decree in the San Bernardino, CA jails. I was also a Federal Court appointed security expert in a U.S. Virgin Islands Jail consent decree. I have

frequently conducted operational reviews of jails and prisons for the National Institute of Corrections (NIC) a branch of the U.S. Department of Justice. Over the past 35 years, I have co-authored three book length monographs published under NIC auspices. A copy of my resume is attached to this report as Appendix A.

I have served as an expert on law enforcement and corrections issues for more than 15 years. In the last few years, expert work has constituted approximately 15% to 40% of my total professional time. I charge $325 per hour for consultation, document review and other preparation activities and $425 per hour for actual testimony at trial or in deposition. My compensation will not be affected by the outcome of this case. A copy of cases I have worked on as an expert is attached to this report as Appendix B. A copy of my fee schedule is attached as Appendix C. Also, my recent publications are also attached to this report as Appendix D.

I was retained as an expert in this action by David Utter, Esq. of The Claiborne Firm. P.C., of Savannah, Georgia, in November, 2017. Mr. Utter represents the Plaintiff in this case, and he requested a written report of my professional opinions about this case.

A list of documents I reviewed for this case is presented as Appendix E to this report.

In addition to the documents listed in Appendix E, I also reviewed the American Correctional Association Jail Standards, "Performance-Based Standards for Adult Local Detention Facilities, Fourth Edition, June, 2004; the National Commission on Correctional Health Care standards, "Standards for Health Care Services in Jails", 2014, and the State of Louisiana Jail Standards.

I am not a medical expert and I have not been asked nor have I attempted to form opinions about medical treatment issues in this case. As an expert on law enforcement and corrections issues for more than 25 years, however, I understand well the critical importance of health care and corrections staff coordinating and communicating to work together to protect inmates in their care, custody, and control.

I requested a tour of the areas of EBR relevant to this case and that tour was scheduled but then cancelled at the last moment and it is my understanding there is a motion in front of the Court requiring that EBR accommodate my request to tour/inspect. I believe such a tour will assist me to further develop opinions in this case, which is why this is a preliminary report.[1]

This case is one of three suicide cases filed against the City of Baton Rouge and other Defendants by Mr. Utter and the Claiborne Firm, representing the various Plaintiffs in these cases. I have been retained as an expert in all of these cases. For obvious reasons, these three lawsuits are not independent of each other. EBR, the EBR policies, the EBR management, and some other factors are either the same or similar in all three of these cases.

I reserve the right to add to or change the opinions in this report if and when additional relevant information becomes available to me after the date of this report.

A note about abbreviations and references may be helpful. Throughout this report, I have referred to the East Baton Rouge Parish Prison as "EBR." When the reference is to the East Baton Rouge

[1] On April 24, 2018, I toured EBR for Plaintiff in the *Lewis v. City of Baton Rouge, et al.* matter, another suicide case. While the focus of that matter was the Q8 dorm and a different segregation unit, M01, I was able to walk down the N01 line. I did not physically tour the N02 line because I was told that the conditions and layout on N02 are identical to N01.

Sheriff, that term is spelled out. I have referred to the various living areas of EBR as "units," as in "the N02 Unit," although most of the inmates and the some of the staff refer to the various housing areas as "lines," because of the linear nature of many of the housing areas. "Housing Unit" is common and generic while "line" is local and colloquial. With regard to time, if I have not specified a particular time in a discussion, then the reference is to the late October, 2016 to early February, 2017 time frame when Jonathan Fano was incarcerated in EBR.

All of my opinions in this report are to a reasonable degree of professional certainty.

III. Method

A. The crux of this case is Plaintiff's contention that Defendants had a duty to protect inmates in EBR from the known threat of harm, including harm from known medical and mental health conditions and harm from suicide by providing medical and mental health care commensurate with accepted community standards of care, and by providing comprehensive suicide prevention policies and practices consistent with contemporary correctional practices across the United States. Defendants knew that if they failed to fulfill that duty it was reasonably predictable that one or more inmates would suffer serious harm up to and including death; that Defendants did in fact fail in their duty to protect the inmates in EBR from medical distress and failed specifically with Mr. Fano; and that his death was a direct result of Defendants' failure to protect him from the known threat of suicide. Defendants argue that they fulfilled their duties to protect Mr. Fano.

B. Within contemporary American corrections there is well-established methodology for addressing the kinds of questions raised in this case. The first step is to determine the applicable duties, looking to relevant law and regulations, to departmental policies and procedures, to professional standards and to widely accepted correctional standards and practices. The second step is to determine whether the various duties identified have been complied with or have been breached by examining the documents and other information available in the case as well as facts from other sources that might illuminate the defendants' compliance or lack of compliance with the various duties identified. An additional step in this analysis is to examine the existing policies, procedures and practices to determine whether they are wrongly formulated or insufficient. That is most often accomplished by comparing them to legal and regulatory requirements and/or to comparable policies, procedures and practices in use in other correctional agencies. An additional important step in this method is to, where possible; review the results of the policies, procedures and practices in question to determine whether they have been effective at accomplishing their objectives.

C. The method summarized above is not exclusive to expert analysis of prisoner tort cases alleging failure to protect. It is also the general method used for auditing correctional institutions for accreditation, whether by the American Correctional Association (ACA) or by the National Commission on Correctional Health Care (NCCHC). It is also used as a major component in critical incident reviews (also called "after-action reports") following major crises or emergencies in jails or prisons. This consultant has used this method for critical incident reviews following a number of very high profile crises in correctional institutions and I have also used this methodology as the central approach on the occasions when I have been commissioned to evaluate the emergency readiness of a particular correctional agency or correctional facility.

D. In addition to the method discussed above, the analysis of the record in this case must also reach the questions of whether it was reasonably predictable that the harm that occurred to Mr. Fano would occur if the various identified duties of the Defendants were not fulfilled, and whether the harm that befell Mr. Fano in this case was a direct result of the breach of those duties by the Defendants.

E. The second method has to do with situations in which there are fundamental disagreements about what factually transpired. The first step in this procedure is to identify each action, behavioral procedure or other occurrence according to each side in the factual dispute (and it is possible that there are more than two sides). Then, each of these disputed steps, behaviors, actions, decisions, or the like must be analyzed against prevailing practices in the facility, specific agency policies and generally accepted correctional practices. They must also be analyzed for internal consistency. That is, from the standpoint of correctional policies, procedures and practices in the facility, as well as generally accepted correctional practices, are the various occurrences, decisions and behaviors described by the Plaintiff consistent with each other? Put another way, does the Plaintiff's story make sense, not because of the credibility or lack of credibility of the Plaintiff, but because of what is known about prison policies, procedures and practices. Then the same analysis must also be performed with regard to the Defendants' story.

IV. The Duty to Protect

A. There is no question that County/Parish jails have an obligation to protect inmates from known threats of harm, including self-harm. In general, when individuals are incarcerated there are a number of ways in which they cannot protect themselves. That protection becomes the responsibility of the incarcerating authority. The classic example is that in a fire, inmates locked in their cells are as helpless to protect themselves as horses locked in a barn. Likewise, the duty of jails and of jail staff to protect inmates from harm is long-standing, basic and consensually accepted throughout U.S. corrections. This duty includes the duty to protect inmates from violence from other inmates, the duty to protect them from excessive staff uses of force, and the duty to protect them from the known risk of self-harm.

B. Moreover, a person in the community can take themselves to a hospital emergency room or other emergency clinic if seriously and acutely ill, while an incarcerated individual is dependent on the correctional facility to provide access to medical and mental health care. Without access to medical care, the seriously ill person may suffer permanent harm or even death.

C. A second problem is that the medical care in a correctional facility must be adequate. If it is substantially sub-standard compared to care in the community, then serious harm or even death may result.

D. There has been a strong trend over the last thirty years for jail and prison systems to contract with third parties for inmate medical services, and often inmate mental health services as well, with private providers that specialize in providing such services to correctional facilities. It is important to note that contracting for these services does not in any way diminish a jail's duty to provide medical and mental health services that are not deliberately indifferent to the serious needs of the jail population. A jail cannot "contract away" its Constitutional duty to provide adequate medical and mental health care to inmates.

E. The specific duty of jails and jail staff to protect inmates from medical disorders by providing comprehensive medical and mental health services while in jail is well established and found in state and federal case law, in state statutes and/or state jail standards, in national jail standards and in policies in almost all jail systems.

F. The duty to provide medical and mental health services to jail inmates is not esoteric. It has received a great deal of attention nationally over the last thirty years within the field of corrections and is a central concept in jail management.

G. Defendants do not dispute their general duty to protect inmates from known risk of harm nor do they dispute their specific obligation to provide medical and mental health services, including suicide prevention services, to inmates at a level that is consistent with the standard of care in the community.

V. Analysis and Opinions

A. The General Condition and Operation of EBR

1. Before reviewing the specific issues that affected Jonathan Fano prior to his suicide at EBR in early February 2017, it is important to look at the context within which that suicide occurred. That is, what kind of a jail was EBR? The answer is clear: EBR was a very bad jail. It was not the worst jail in the United States, but it would have been at home in that competition. Every aspect of the jail, from staff use of force to inmate-on-inmate violence, to policies and procedures, to staff professionalism, and much more, ranged from inadequate to deplorable. This case record provided information on many aspects of EBR and none of that information was positive or encouraging.

2. There is no single criteria or set of criteria that is consensually accepted as measuring the quality of a jail. However, one measure that is something of a "bottom line," is death rates within the facility. In 2012, the death rate per hundred thousand prisoners in the United States was 129 but at EBR, that same year, the mortality rate was 532, or more than four times the national average. In 2013, the mortality rate for EBR prisoners was 34% higher than the national average. In 2014, the mortality rate at EBR had risen to 90% higher than the national average (US DOJ, Bureau of Justice Statistics, "Mortality in Local Jails 2000-2014"; Farris, S. and Armstrong, A., Dying in East Baton Rouge Parish Prison; July 2018). Death rates at EBR declined somewhat in 2015 but were still substantially above the national average and then in 2016 approximated 300% higher than the national average. In January, 2017, the Council changed from medical and mental health services at EBR operated by the Parish (Prison Medical Services, or "PMS") to a private, for-profit, health services company, CorrectHealth. That change might have been predicted to decrease the extraordinary mortality rates at EBR but instead the mortality rate, in the two and a half years after CorrectHealth assumed responsibility, reflected a 36% increase when compared to the already extremely high death rate for previous the five years at EBR. Put another way, the 17 deaths in the two and one-half years after CorrectHealth took over at EBR is more than three times the national average (140 per 100,000) for deaths in jails (Walter Smith deposition, Exhibit 2).

3. It is not the intent of this report to attempt an analysis of all facets of the EBR operation. Still, a surprisingly informative sense of the nature of EBR can be found in the experience

of two former inmates. Daniel Hinton was an inmate at EBR and was housed on N02 at the same time that Jonathan Fano was there. Mr. Hinton had been at EBR before and testified that sometimes a new inmate would not see a medical person at intake (Hinton deposition, pgs. 18-19, lines 15-3), an allegation confirmed by an assessment of EBR's health care system performed in 2016 by HMA. He said there were always problems at EBR because people there simply did not do their jobs (Hinton deposition, pgs. 20-21, lines 14-15). He said that he had been misclassified and filed a grievance, but nothing was done about that (Hinton deposition, pgs. 21-22, lines 16-6). He said that this time he was initially placed on Unit F5 for a few hours but that inmates there jumped him and would have killed him except that the staff happened to call for mealtime. The beating left him with fractured ribs and a broken ear drum (Hinton deposition, pgs. 23-24, lines 9-18). Mr. Hinton said that even if you had a medical emergency, you wait. "They see you when they see you." That was true even when he experienced chest pain (Hinton deposition, pgs. 30-31, lines 5-15). Mr., Hinton also said that the medical staff were rude and not professional (Hinton deposition, pgs. 66-67, lines 16-6). With regard to the serious beating Mr. Hinton suffered at the hands of other inmates, he was asked at his deposition about his experience in other jails and Mr. Hinton noted that he had been in several other jails but getting beaten by other inmates was "mostly an EBR thing." (Hinton deposition, pg. 123, lines 9-17).

4. Frank Brooks had been incarcerated for six days at EBR in 2011 and then was back at EBR beginning on January 18, 2017. He was initially placed on Unit F3 but was assaulted by other inmates there and was then placed on suicide watch for approximately five days. He got no medical attention for his bloody nose and bloody lip that he received during the fight on F3 (Brooks deposition, pgs. 14-15, lines 15-4). Mr. Brooks testified that he was put on suicide watch in spite of the fact that he had not threatened suicide and was not suicidal. He said that he was placed on suicide watch by Deputies who were angry at him because he would not inform on the inmates who had been in a fight with him (Brooks deposition, pg. 18, lines 1-20). Mr. Brooks testified that no nurses were called after the fight or to his suicide cell after that, and that when he was taken off suicide watch, his nose was still bleeding on the inside and he wanted medical attention. When the nurses would come past his cell during medication pass, he said that the deputies would tell them to leave him alone and they would not give him any medical attention (Brooks deposition, pgs. 21-22, lines 10-4). Mr. Brooks described a situation in which he did directly tell nurse Granger that he needed medical attention, but she looked at the deputy who was accompanying her and asked whether she should respond to Mr. Brooks, and the Deputy said that she should not (Brooks deposition, pg. 22, lines 5-25). Mr. Brooks also testified that on the one occasion on which he saw the social worker, Ms. Eichelberger, he told her that he needed medical attention, but she did nothing about it (Brooks deposition, pgs. 23-24, lines 23-2).

5. While Mr. Brooks was on N02, he was allowed out of his cell for 30 minutes a day, 3 days a week and for fifteen minutes a day on the other four days a week (Brooks deposition, pg. 30, lines 4-23). That out of cell time included time for the inmate to shower. Inmates were not taken to a recreation area and were limited to walking up and down the corridor when they were allowed out of their cells. Mr. Brooks was asked whether any of the CorrectHealth medical staff had ever used racial slurs towards any of the inmates on N02. Mr. Brooks said that he had asked for something for a headache and that the nurse, Ms. Granger, had then

called him and the inmate housed next to him, Daniel Hinton, "niggers"[2] (Brooks deposition, pgs. 54-55, lines 20-23). Mr. Brooks was next asked whether he had submitted a request for sick call and he explained that they could not do that on N02. He said they do not allow pens or pencils or anything to write with and that the deputies do not give you a slip for sick call. There were other references in the case record to the fact that inmates on the lockup units often did not have access to sick call requests, a serious failing also corroborated by the HMA report as a facility wide issue regarding barriers to accessing health care. Mr. Brooks said that even if there was a medical emergency, other inmates would have to make noise to get staff attention and that can take a while (Brooks deposition, pg. 56, lines 14-20). When Mr. Brooks was asked whether any of the security staff had used racial slurs towards him or any of the other inmates, his answer was, "Deputy Noorwood, Lieutenant Lamant, Deputy King, Lieutenant McFarland, and Sargeant Roof." He added that they were the only individuals he could think of at that time who had used racial slurs (Brooks deposition, pgs. 57-58, lines 6-10). Mr. Brooks was asked how often the Deputies walked up and down N02 ("rounds", which was required every thirty minutes). Mr. Brooks testified, "maybe once every three to four hours, maybe" (Brooks deposition, pg. 58, lines 20-22). He added that the deputies rarely used the catwalk to walk and up and down the line and said, "maybe once a day, maybe," and explained that you can hear the gate open and close and from his cell he could see who was coming and going on the catwalk when the gate opened or closed because he was at the front of the cell line.

6. The picture painted of EBR in the depositions of Mr. Brooks and Mr. Hinton is not dissimilar from the picture that emerges from the record of Jonathan Fano in this case. Inmates are kept on N01 or N02 for long periods of time and even though they may be mental health inmates or protective custody inmates, they are treated as if they were on disciplinary segregation. They do not have access to programs and most services are not afforded to them. Staff do not supervise the area appropriately and even when an emergency occurs, inmates must figure out how to let staff know and get staff to respond. The situation experienced by inmates on N01 and N02 is substantially worse than what was described to the Council by public officials when they stated it was an emergency.

7. Some of the important aspects of a jail's operation are not considered in this report because they are not central to what happened to Jonathon Fano, even though they are defining for those incarcerated. One of the most obvious of those issues is staff use of force. Multiple inmates complained that staff beatings were not uncommon. One inmate described how staff would put an inmate in lockdown after he was beaten, so that he would have no visits until his wounds had healed. Lest these allegations be dismissed out of hand as inmate inventions or exaggerations, it is worthwhile to consider Sgt. Cage's deposition testimony. When asked about one of her several disciplinary suspensions, she explained that she had sprayed an inmate with OC because she was angry with him. He had been masturbating but was no longer doing that when she sprayed him because what he had been doing was "nasty". She then didn't report her use of force. Either using force so clearly as corporal punishment or failing to report a use of force would lead to termination, or close, in most well- run jails. Instead, Sgt. Cage got a short suspension and no demotion, and her several disciplinary incidents did not deter her promotions.

[2] Throughout Mr. Brooks' deposition, both he and the questioners use the "n-word" to describe this racial slur. I chose to use the actual word because of how jarring it is to hear it in this day and age, and to convey how offensively EBR staff address the inmates.

8. Other staff corroborated in their own sworn testimony, some of the most telling intimate criticisms of the EBR. Deputy Monroe, in his deposition, admitted to logging inaccurate information (Monroe deposition, pg.43, lines 8-14). He also acknowledged that deputies sometimes ran out of sick call slips (Monroe deposition, pgs. 48-49, lines 8-13), that he had used excessive force and filed a false report (Monroe deposition, pgs.64-65, lines 5-10). Sgt. Cage described deputies cursing, causing a disturbance and then fighting with inmates (Cage deposition, pgs. 35-36, lines 24-17).

B. Jonathan Fano was Severely Mentally Ill

1. On October 30, 2016, Jonathan Fano took a bus trip from Miami to join his family at their home in Southern California. According to his family, Jonathan was hallucinating, and more specifically hearing voices, during the bus trip. As a result of the voices in his head, he decided to get off the bus at a stop in Baton Rouge, LA. There, on Oct 31, Jonathan was arrested by the Baton Rouge police. He had been creating a disturbance in the downtown area of Baton Rouge and when the police found him, he was running around naked except for a shirt, swinging his penis and explaining that he and his friend, Titianna, were both cross-dressers and that they were looking for some kind of show where they could make money. Titianna was an imaginary friend. Mr. Fano was arrested and charged with disturbing the peace, obscenity, resisting arrest, and battery on a police officer, among other charges. He was taken to EBR. He should have been taken to a psychiatric emergency facility in the community instead.

2. At the time of his arrest Mr. Fano was 27 years old. He was a small and slight (5'7", 130lb) Hispanic male. He had been diagnosed as seriously mentally ill and on anti-psychotic medication since at least 2013.

C. EBR was Ill-Equipped to Manage Mentally Ill Inmates

1. EBR had inadequate facilities, mental health services, staff training and other severe deficits that prevented reasonable treatment of mentally ill inmates. This is not just my conclusion as a result of reviewing the record in this case. It is also the conclusion of the EBR jail administrators, the East Baton Rouge Sheriff and East Baton Rouge Parish officials. Further, that conclusion was corroborated by a detailed and comprehensive independent study specifically commissioned by the Parish to evaluate the prison. The long-time Warden of EBR, Dennis Grimes, testified at his deposition, "The design of the prison proposes a risk for everybody because of the way it's designed." (Grimes deposition, pg. 38, Lines 5-17). When Warden Grimes was asked about a Metro Council meeting in January 2015, at which William Daniel described the situation at EBR as it related to mentally ill inmates as "dire", Warden Grimes testified that he would say that the situation was "urgent" rather than dire (Grimes deposition, pg. 41-42, Lines 25-3). Warden Grimes went on to detail that EBR needed a mental health unit and more and better housing (Grimes deposition, pg. 43, lines 3-11); that he knew that the bars and sprinklers could be anchors for ligatures and suicides (Grimes deposition, pg. 33, lines 1-21); that because the facility is old there were plumbing and security issues, and that inmates could "pop the gates", jimmy or block the locks, etc.; and that there were mental health inmates all over the prison. Warden Grimes went on to testify, "mental health people should not come to the prison because there are not enough staff to accommodate those people. It is not designed or equipped to handle those individuals" (Grimes deposition, pg. 35, lines 9-16). That is a candid and blunt admission

that what happened to Jonathon Fano was inexcusable because the EBR management knew that he never should have been there.

2. The Warden was not alone in his assessment. The Sheriff told the Council that the physical condition of the prison was "deplorable" and the Warden agreed with that assessment (Grimes deposition, pgs. 107-108, lines 21-5). The Sheriff also told the Metro Council that he had a safety concerns for both staff and inmates, and more specifically that EBR did not have adequate medical and mental health care for inmates, and Warden Grimes agreed with both of those statements (Grimes deposition, pg. 108-109, lines 6-2). Warden Grimes also testified, "medical, the infirmary, not capable of having the thing we need for the inmates' mental health needs as far as a place to put those individuals so they can be monitored by medical" (Grimes Deposition, pg. 109, lines 4-8). These statements remove any doubt that the Sheriff, the Warden and the Council knew full well that a seriously mentally ill inmate such as Jonathon Fano did not belong at EBR and would be in predictable jeopardy if placed there.

3. For almost all of his stay at EBR until his suicide, Jonathan Fano was on the N01 Unit and the N02 Unit. Warden Grimes admitted in his testimony that M and N units would have been shut down if Federal officials had come in and inspected the facility (Grimes deposition, pgs. 114-115, lines 20-7). The Sheriff also told the Council that EBR did not have "adequate medical and mental health care for inmates", to which Warden Grimes agreed (Grimes Deposition, pgs. 108-109, lines 13-2). At a January 14, 2016, meeting of the Council, the Sheriff's attorney, Mary Erlingson, told the Council, on behalf of the Sheriff, that there was no room to segregate mental health inmates and that "this is an emergency." Warden Grimes agreed that there was no appropriate place in EBR for mental health inmates and that was still the situation at the time of his deposition (Grimes deposition, pgs. 106-107, lines 20-3).

4. The testimony and opinions reviewed above are extraordinary. They paint a picture of a jail that was in very poor condition overall and which specifically could not safely incarcerate or manage mental health inmates. These are not opinions presented by inmate advocacy groups or attorneys for plaintiffs, but rather they are the opinions of the Warden of the jail, the Sheriff of the Parish and the Parish Administrator. The long accepted and well-established standard for health care and mental health care in jails and prisons across the U.S. is that those services for inmates must be equivalent to the medical and mental health services available in the community. EBR and the Sheriff cannot argue that they were not on notice that mental health facilities and services at EBR were dramatically below acceptable standards or that those facilities and services did not pose a serious risk of permanent harm or even death to mentally ill inmates, because it is the Sheriff, the Warden and the head of the Parish who were making those arguments publicly to the Council.

5. In the face of that situation, there were two acceptable paths for EBR and the Parish. They could either fix the conditions at EBR with regard to mentally ill inmates or they could stop incarcerating mentally ill inmates at EBR. That latter solution is not as impossible as it sounds because EBR was seriously overcrowded at the time and was already sending hundreds of East Baton Rouge inmates to other facilities. The Parish could have made the decision to not accept mentally ill inmates and to send those that had to be incarcerated to other facilities. Tragically, EBR and the Parish took neither of those courses of action and Jonathan Fano's suicide was a direct and predictable result.

D. The HMA Study

1. In 2016, the East Baton Rouge Parish contracted with an independent consulting group with expertise in medical and mental health procedures and services in correctional facilities. That group, HMA agreed to do an in-depth assessment of clinical operations at EBR. The scope of the study included staffing, pharmacy, medication, administration, quality improvement and performance, records, utilization of specialty services, treatment of communicable diseases and chronic care, suicide prevention, and mortality reviews. Each of those areas was compared and contrasted with the Louisiana state standards and with national correctional standards as reflected in the ACA standards and the NCCHC standards. Data collection and interview trips for the HMA study were primarily conducted in early 2016 and a final report was presented to the Council in early June, 2016.

2. A complete review of the HMA findings is beyond the scope of this report. However, some of the HMA findings are clearly relevant to this case. HMA found that inmate access to healthcare was found to be seriously deficient for several reasons, including that sick call request slips had to be requested from a correctional officer and that medical and mental health staffing patterns were woefully inadequate (the Warden testified at his deposition that prior to his job at EBR, he had worked at state prisons and that he was used to having six social workers for an inmate population the size of EBR, and that EBR had one social worker (Grimes Deposition, pg. 97, lines 10-20)). HMA found that the health and mental health budget for EBR was five million dollars annually and that adequate staffing for medical and mental health positions would require an annual budget of 10 million dollars. HMA noted that there were 30% nurse vacancies and that the authorized full-time nursing positions were inadequate. The result of that situation was that medical and mental health staff were commonly working beyond their credentialed practice, that physician hours authorized were approximately one-third of those required and that psychiatrist hours were similarly about 40% of what was required. In response to what should have been an alarming report corroborating the testimony of the Warden, the Sheriff and its Acting Administrative Officer, and highlighting many other serious problems, the Parish and EBR did little except to change from medical and mental health services operated by the Parish to contracting for those services with a private, for profit organization, CorrectHealth.

E. Jonathan Fano's Intake at EBR

1. Some of the mistakes that were made by EBR with regard to Jonathan Fano are so serious that they are difficult to comprehend. On the Prisoner Transport Record (EBR 1760), the Deputy transporting Mr. Fano to the EBR has to answer the question, "have you observed any mental health problems?" His written response is, "No." How is it possible that someone who was arrested on the streets running around naked and talking about his imaginary friend is not exhibiting any signs of mental illness? When a new prisoner is brought to a Jail, the individual is processed, usually referred to as "Booking and Intake." In most jails, that involves intake policies, a number of forms, and a substantial procedure. There are good reasons for all that. Is the new inmate who he or she says they are? Is the person wanted in some other jurisdiction for serious crimes? Is the individual on medication which will be life-threatening if discontinued? Is the inmate currently suicidal? There are, of course, many other important questions.

2. In most jails, a new inmate is first screened by a correctional officer or deputy and one of the key questions that must be answered first is, "should this person be admitted to the jail or does this person have injuries or medical or mental health problems that require the jail to refuse admission and direct the police officer to take the individual to a community hospital for treatment and or for clearance that they can be safely be admitted to the jail?" At EBR, Deputy Breeding testified that he had worked in intake the majority of his time employed by EBR and had never rejected a new prisoner for mental health reasons (Breeding Deposition, pgs. 36-37, lines 26-3). Then, if the person does not have immediate and possibly emergent medical or mental health issues, they are fingerprinted and go through other steps in the booking process. That includes an initial screening for medical, mental health, and suicide issues. The next step is typically a more in-depth medical screening by a medical staff member.

3. In Mr. Fano's case, it appears that much of the usual booking and screening process was ignored. There are some admitting records, but they are minimal. It does not appear that Mr. Fano received any thorough services and the minimal medical or mental health screening he did receive made recommendations that were not followed for months. That is not a complete surprise since HMA documented in their report that they estimated that somewhere over 10% of new admissions to EBR received no medical screening at all. Included in Mr. Fano's admitting document package is a form that says, "admitting deputy must read to inmate: by signing below…" That form documents that the inmate has been told about mail regulations, that he or she has received a copy of the inmate rules and the inmate disciplinary regulations, and that the Deputy has discussed the grievance procedures with him or her. In Mr. Fano's case, the document is blank. His signature is not on the document and neither is the signature of the Deputy or the Deputy's supervisor on the document. It would appear that Mr. Fano did not get a copy of the rules and disciplinary regulations nor did he have the grievance procedures explained to him. Perhaps he did not know that there was an inmate grievance procedure that he could have used when his requests for medical services were ignored. Even the fingerprinting of Mr. Fano was somehow missed, with the arresting officer claiming the booking Deputy should have done it and Deputy Breeding claiming that Officer Bennett should have done it.

4. The screening from that is in the case record for Mr. Fano includes questions about mental health history and about prior care from a mental health provider and about psychiatric medications. The form lists a "No" answer from Mr. Fano to each of those questions. That is difficult to reconcile with Mr. Fano talking openly about his delusions with the police and about his suicidal thoughts with inmates, mental health staff and family. It is noteworthy that the HMA study reported inconsistent screening practices and intake staff sometimes skipping portions of the intake interview. Booking staff at any jail have access to a new inmate's arrest charges and the nature of Mr. Fano's arrest would have indicated to almost anyone that he likely had a serious mental health history.

5. The PREA screening checklist (001761) is filled out for Mr. Fano. The purpose of that checklist is to identify, at intake, inmates who may be predatory and to also identify those inmates who are likely to be victimized. Once so identified, those inmates can then be classified and or housed in such a way as to minimize the risk that has been identified. On that checklist, question number four asks whether the individual is of small physical stature, which is defined as under 140 pounds. The classification officer at intake, Corporal J. Freeman, has written "no" although Mr. Fano is 130 pounds. The next question, number

five, asks whether the individual has developmental disabilities or mental health issues. The staff member has not answered that question and has simply drawn a diagonal line where the "yes" or "no" would typically go. Another question asks whether the individual is homosexual/Bi, LGBTI, and/or gender nonconforming. The classification staff member has answered "yes." The form specifies that if two or more questions are answered "yes" then the staff member is directed to enter a code for "potential victim." In Jonathan Fano's case, there should have been three questions answered "yes" but since one of those was incorrectly answered "no," and another was not answered, Mr. Fano was not given the "potential victim" code which might have led him to be housed in a more appropriate area. Instead, with no medical or mental health screening, and an incorrect identification as unlikely to be victimized and no awareness of his serious and extensive mental health history and current mental health problems, Mr. Fano was sent to a small dormitory of general population inmates where, within hours, he attempted suicide by cutting a wrist.

F. EBR Reaction to Jonathan Fano's Suicide Attempts

1. When Mr. Fano's suicide attempt was discovered, he was taken to a local hospital, treated and then returned to EBR. He was placed on suicide watch and given a November 2nd appointment with a social worker "for suicide precautions." That appointment was marked "highest priority." The appointment was not kept. Although it strains credulity, the emergency medical request form that was filled out at the time of the suicide request says "no mental health history" even though the narrative states that Mr. Fano was hearing voices and had made a suicidal cut to his wrist. Beyond that, no one had attempted to ascertain any of his history, mental health or otherwise. His placement on suicide watch noted depressed mood and bizarre thoughts and behavior. On November 3, 2016, two days after suicide watch, Mr. Fano was seen by the prison psychiatrist, Dr. Blanche, who discontinued the suicide watch. Photos of Mr. Fano's suicide watch cell on unit N02 show it to be filthy and foreboding with open bars across the cell front that made it remarkably inappropriate for a suicide watch cell. That is, the open bar design offered a multitude of quick and easy places to anchor a ligature during a suicide attempt.

2. On November 4, Mr. Fano was given an appointment to return to the clinic and see a psychiatrist after one month. That appointment also was not kept. It is noteworthy that Mr. Fano came in to the jail after having been arrested in a floridly psychotic state, running through a downtown area naked and talking about an imaginary friend. In spite of the hallucinations and delusions, he was not identified as mentally ill at intake and appears to have received no thorough medical screening. After a clear suicide attempt within hours of his assignment to general population housing, Mr. Fano was sent to an emergency room with a notation that said "no mental health history." When he returned to the jail from the hospital, there was no follow-up with hospital medical or mental staff or any attention to follow up care. His highest priority appointment with a social worker the day after he returned from the hospital was ignored, as was his return visit with a psychiatrist scheduled for him a month later. When Mr. Fano was removed from suicide watch by Dr. Blanche, it was not the result of a comprehensive suicide risk assessment; instead, Dr. Blanche used his common procedure of evaluating Mr. Fano at his cell front, through the bars. The logs produced documenting Dr. Blanche's clinical meetings with inmates demonstrate that he usually spent two to six minutes talking with or seeing a particular inmate and then moved on to see the next inmate at a cell front, through the bars. It was unusual to find entries indicating Dr. Blanche had spent a substantial amount of time with a particular inmate. It is

also a matter of concern that for convenience Dr. Blanche talked with inmates at their cell front, where it is not possible to have any privacy for the clinical contact. That can be a particular problem for an inmate new to the jail, such as Jonathan Fano.

G. Mr. Fano is Disciplined for His Suicide Attempt

1. Rather than conducting a thorough medical and mental health work-up of Mr. Fano because of his suicide attempt, and rather than providing him with any kind of intensive mental health treatment or programming, EBR gave Mr. Fano a "disciplinary write-up" for "self-mutilation" and the disciplinary board (actually a lieutenant and one other staff) sent Mr. Fano to disciplinary segregation ("the hole") for a 20 day sentence with several days credited for time served. Mr. Fano was transferred to unit N02. His segregation time meant he was not allowed visitors or family phone calls.

2. When the Warden was asked at his deposition about the appropriateness of imposing discipline on a seriously mentally ill inmate, the Warden explained that the disciplinary board would refer the incident and the inmate to mental health and that the mental health staff would then evaluate whether the inmate should be accountable for the incident by way of sanctions. That did not happen in Mr. Fano's case. When the audio recording of the disciplinary board was played for Lisa Burns, the EBR Social Worker through 2016, she reacted strongly to the recording, saying she found it "very disturbing" (Burns deposition, pgs. 48-49, lines 22-13). The reason she found it so disturbing was that she heard the board members say they were going to refer Mr. Fano to her but she knew they did not do that and that he subsequently committed suicide (Burns deposition, pgs. 49-50, lines 24-20).

3. The central issue here is that responding to an inmate suicide attempt with discipline instead of treatment is contrary to everything that is known about suicide or inmates and it is also barbaric. If an inmate is distraught and or seriously depressed, isolation will increase – not decrease – the risk of future suicide attempts. Some inmates like Jonathan Fano are in jail without family or friends on the outside, either because of their history of criminal behavior or their mentally disturbed behavior, or both. Jonathan Fano was very fortunate in that he had family members who had not given up on him, who cared deeply and who were in touch while he was in jail. It does not take a genius to figure out that if an inmate is depressed, distraught and suicidal, one of the last things that should be done would be to prevent family visits and family phone calls, separating the inmate from one of his few areas of strength and positive relationships.

H. Mr. Fano's Additional and Unreported Suicide Attempt

1. In his sworn statement, former inmate Emanuel Jones said that Jonathan Fano, "tried to hang himself a few days before he was successful. I actually saw it from the reflection in the catwalk's glass – either the knot or the clothe broke, but he definitely tried and failed to kill himself. I told Dep. Monroe about it, and told Monroe that he needed to get Fano help and move him to a cell closer to the cage so guards could watch him." That is not some eccentric story that is found only in Mr. Jones' statement. Evidently, when Mr. Fano tried to hang himself a few days before his actual suicide, the ligature broke and he fell with enough noise that other inmates realized what happened or were able to piece it together. At his deposition, Mr. Hinton said that he and other inmates knew that Mr. Fano had tried and

failed to commit suicide when the ligature broke (Hinton deposition, pgs. 72-73, lines 21-15).

2. This is the most egregious aspect of this case. There is no reasonable basis to doubt the sworn testimony of multiple inmates that Mr. Fano attempted suicide a few days before February 2, and that he failed. Mr. Jones is clear that he told a specific staff person, Deputy Monroe, and advised him that Mr. Fano should be moved to a location next to the cage where he could be observed. That advice was correct and it should not have been incumbent upon an inmate to point out to the staff that Mr. Fano's cell location exacerbated the risk that he would commit suicide. When the security staff were told that Mr. Fano had attempted suicide, they should have immediately placed Mr. Fano back on suicide watch and notified mental health to do an immediate evaluation of him. Those steps needed to be taken whether staff had doubts about the credibility of the inmate stories or not, because the rule of thumb in dealing with inmate suicide risk is to err in the direction of safety. Beyond that, if the mental health staff were making daily checks on the inmates on N01 and N02, they would have heard from other inmates about Mr. Fano's suicide attempt and they would have been able to talk with Mr. Fano and evaluate his condition even if the deputy who heard about Mr. Fano from other inmates had not reported anything.

I. Units N01, N02, M and the Lack of a Mental Health Unit at EBR

1. As noted earlier in this report, the Sheriff, Warden Grimes, and the HMA consulting group all spoke strongly about the lack of a mental health unit at EBR. Both the Sheriff and Warden Grimes took the position that since it was not possible to have a mental health unit in the current facilities, EBR had no choice but to scatter mental health inmates throughout the jail while placing most of the seriously ill individuals on M, N01 and N02. Those assumptions are simply wrong. There is no good correctional reason that EBR could not have converted one of its large dormitories into a mental health unit, with both security and mental health staffing. Certainly, the most acutely disturbed and or violent mentally ill offenders would not be appropriate for a dormitory setting and would need to be housed in cells. However, that would not apply to the vast majority of mental health inmates and it would not have applied to Jonathan Fano. There is a large and growing body of evidence that restrictive housing, isolation and solitary confinement are antithetical to therapeutic objectives with mental health inmates and lead to increasing decompensation and increased suicide risk. It has been established for some years that even double celling inmates with some suicide risk or suicide history is generally safer than single celling. In short, more contact is generally better than less contact for depressed and or suicidal inmates and a social atmosphere can be helpful even if it is not a well-designed and well-staffed therapeutic community, although that is certainly possible and should be the objective in jail mental health units.

2. Beyond the positive aspects of increased interaction with other individuals for the depressed inmate, there is also a built-in check against suicidal behavior. Inmates do not want to see another inmate kill himself or herself, any more than inmates want to watch as an inmate dies because of lack of medical care. Even with an inmate who may be difficult or obnoxious to other inmates because of mental illness, if that inmate is seen starting to hang himself or herself, other inmates will almost always start to yell and alert security staff that there is a hanging in progress.

3. It must be emphasized that a dormitory converted to some form of mental health unit is not the only option that was and remains open to EBR. For some reason that is baffling, perhaps historical accident, EBR uses N01 and N02 for a combination of protective custody inmates, administrative segregation inmates, mental health inmates, suicide watch inmates, and disciplinary segregation inmates. Each of those five categories of inmates is distinct and different from the others. Each should have its own rules, regulations, privileges, restrictions and programming. At EBR, that is not done and everyone on N01 and N02 is treated very similarly. Most obviously, all of the inmates are on lock down 23 ½ or 23 ¾ hours per day (with the exception of the occasional inmate worker on the unit). Thus, protective custody inmates and mental health inmates are essentially punished by being kept with, and primarily treated as, disciplinary segregation inmates. Administrative segregation inmates, which technically includes protective custody inmates, are housed apart from general population as a convenience to the facility or for security reasons, but not as punishment. Thus, they should be entitled to all of the rights, privileges, programs, and services that are available to the general population, as long as security is not impaired. Thus, if general population inmates have access to educational programs, vocational training and religious services, the correctional facility is obliged to make best efforts to deliver those programs and services to the housing units holding the mentally ill, protective custody, and administrative segregation inmates, even if that means education programs, for example, must be delivered on a one-on-one basis at the cell front. That is not an uncommon arrangement. None of that occurs at EBR. At his deposition, Warden Grimes was asked about 18 different programs that are available to inmates in EBR and the question was, which of those 18 programs were available to inmates on M and N units. His answer was that none of them were (Grimes deposition, pgs. 124-126, lines 12-5).

4. In reality, if the lack of programs and services on N01 and N02 were the extent of the problems there, it would be a blessing. Inmates largely regard N01 and N02 as a "hell hole," even within a jail that is generally very poor. In his deposition, inmate Hinton said that inmates generally refer to N and M units as "lock down" or "solitary" (Hinton deposition, pgs. 137-138, line 24-14). Inmate Hinton was initially placed in population on unit F5 for a few hours but inmates there "jumped him" and he is convinced they would have killed him except that the staff announced mealtime (Hinton deposition, pgs. 23-24, lines 9-11). As a result of the attack, Mr. Hinton suffered fractured ribs and a broken ear drum (Hinton deposition, pg. 24, lines 12-18), and was then sent to N02 for his protection. He was a "hall man" (inmate porter, or worker) and that allowed him to be out of his cell and around various locations on the unit for long periods of time. He was in a position to know the unit operations well. He said that the medical staff were rude and unprofessional (Hinton deposition, pgs. 66-67, lines 16-6), and when he was asked whether staff used racial slurs, he said that it was "racial all the time" (Hinton deposition, pg. 66, lines 7-15).

5. A number of deposed inmates provided sworn declarations in the Lamar Johnson case and some of these inmates provided testimony about the M and N units at EBR. Marcus Williams' declaration describes M01 as the "crazy line." The louder an inmate gets, the further back in the row of cells they put you. The staff don't want to deal with the inmates and the worst cases are the furthest away from the staff. He also provided testimony that the deputies do not do their required rounds (cell checks) and that drugs were commonly available on the units. Corey Pitman's declaration also included testimony that the deputies frequently skip required rounds. Byron Maxon's declaration included a statement that there was generally a great deal of violence in the jail and that there were frequent assaults on

inmates by deputies. Mr. Pitman's declaration also spoke to inappropriate force by deputies against inmates. Turner Jackson, in his declaration said that there were frequent beatings of inmates by staff and that the inmates would be put in lock down until their wounds healed. He also said there were no calls or visits in lockdown so that it was not possible to show the results of the staff beatings. He described inmates throwing feces, urine and semen on other inmates on the M1 unit where he had been housed. Travis Anderson's declaration described staff putting inmates in the shower for punishment and forcing them to stay sitting there until morning. He also said that inmate beatings take place off camera. Broderick Samuel also provided a declaration and said that deputies talk to inmates as if the inmates are dogs. He described watching deputies beat Lamar Johnson while he was handcuffed. Mr. Samuel further stated that the staff do not clean the cells on the M and N units. Both Michael Lacour's and Christopher Haney's declarations included statements that the deputies do not do rounds, as did Josh Boxie's declaration and Lorenzo McCutcheon's declarations.

6. If, for some reason, EBR had not believed it would be possible to create a dormitory mental health unit, or if they believed that would not be beneficial, there was and there remains an easier and more obvious alternative. That is, N01, N02 or M could be converted to an entirely mental health unit, or perhaps two of those units could be converted, depending on the mental health population to be accommodated. Most inmates could be double celled, which would be preferable where possible but for those inmates too disturbed or inappropriate for double celling for some other reason, they would simply be single celled. The mental health unit could then have staffing 24/7 with a deputy assigned within the unit on the corridor(s) nights and weekends and both mental health/program staff and security staff on the unit days and evenings, and could be operated in an interdisciplinary manner. Then those inmates on suicide watch could be placed in cells adjacent to the staff and station or staff desk on the unit. That would provide far more frequent observation than is the case with the current structure. That would also mean that inmates on suicide watch would have direct access to staff at most times.

J. Mr. Fano's Stay on N01 and N02

1. The chronology of Jonathan Fano's stay on N until his suicide is so disturbing that parts of it are difficult to believe. He was put on N to do the disciplinary time that he received for his suicide attempt. It would be easy to assume that when Mr. Fano had completed his 20 day sentence in disciplinary segregation he would have been moved off that unit to some other part of the jail since he was no longer serving his sentence. That did not happen. Instead, Mr. Fano was left on N for the next three months until he killed himself. Warden Grimes was asked why, after the 20 days had elapsed, was Mr. Fano held in segregation. He answered that it was a disciplinary detention issue (Grimes deposition, pg. 121, lines 7-13). That is contradicted by the lockdown review of Mr. Fano on January 3, 2017, which states that he is on lockdown for "medical/suicide" and that he should remain. That review was inaccurate because Mr. Fano was taken off suicide watch on November 4 by Dr. Blanche and not placed back on suicide watch at any point prior to his suicide. The lockdown review is one of two review procedures described by Warden Grimes as safeguards against inmates remaining on lockdown status for too long or without good reason but one review was never given to Mr. Fano and the other was only done once in over three months and was superficial, ineffective, and had information that was simply wrong.

2. On November 25, 2016, Mr. Fano filled out a medical request form and was scheduled for an appointment to be seen on December 15th. He had been scheduled to see a social worker on November 3rd but that did not happen and he should have been seen for his one month, return to clinic visit, on approximately December 4th, but that did not happen either. Then his appointment to be seen on December 15th in response to his medical request form was also ignored. It should be noted that even if that had been kept, it would not have been safe to wait three weeks after a seriously mentally ill inmate with a recent suicide attempt had completed a medical request form, before he was seen. When Mr. Fano's December 15th appointment was not kept, he filled out another medical request form on December 18th stating that he had "really bad anxiety and depression" and that he was "having really bad thoughts of my time here." Mr. Fano was moved from N01 to N02 on the 20th of December and he had still not seen a clinician.

3. On January 3rd, Mr. Fano was finally seen by a correctional health staff member who noted anxiety, depression and that he was hearing voices. On January 11th, Vincent Bradley of CorrectHealth, saw Mr. Fano because he was not taking his medications and he was not eating. That same day he was seen by Cathy Schley, who noted that she suspected Mr. Fano was faking or exaggerating his condition and that he "presents as stable overall." One week later, on January 18th, Dr. Blanche evaluated Mr. Fano on the basis of a "through the bars" interview at cell front and noted that he (Dr. Blanche), "doubts serious mental illness" and reduced Mr. Fano's anti-psychotic medications for the next week, after which he ordered them discontinued altogether. A week after Dr. Blanche had discontinued Jonathan Fano's anti-psychotic medication, Mr. Fano committed suicide.

4. The evaluation by Cathy Schley on January 11th, in which she decided that Mr. Fano was faking or exaggerating his mental health problems was made without any recent contact with Mr. Fano that would give Ms. Schley a baseline for her observations. Similarly, at the time Dr. Blanche decided that Mr. Fano was not seriously mentally ill and discontinued his anti-psychotic medication, Dr. Blanche had not seen him for 2 ½ months and Mr. Fano had no clinical contacts from November 4, 2016 until early January, 2017.

5. For two months, Mr. Fano – who had just made a suicidal attempt – was locked down in isolation and ignored. Here again, it is not that EBR and the two health providers did not know better or were not on notice. The HMA report earlier in 2016 included an analysis of EBR practices against NCCHC standards and that analysis starkly stated (at p.10, Plaintiff's 000404) that inmates in segregation should be monitored by mental health professionals once per week and by medical staff up to daily, with monitoring documented. That section ends with a warning, emphasized in italics, "inmates who are SMI should not be confined under conditions of extreme isolation." EBR, PMS and CorrectHealth all violated these standards. In fact, CorrectHealth began at EBR on January 1, 2017 but there are only four clinical contacts documented in all of January for Jonathan Fano. The CorrectHealth policy itself for segregated inmates requires a visit from medical and mental health staff at minimum on a daily basis if the inmate is in extreme isolation and three times a week if the inmate is in limited isolation. That policy required 32 contacts by CorrectHealth medical/mental health staff because Mr. Fano's isolation was extreme. Instead of 32 clinical contacts from January 1 through February 1, Mr. Fano received four.

6. None of these CorrectHealth assessments bore any relationship to the views of Mr. Fano by people who were talking with him repeatedly and at length or who were housed near him

and saw him on a daily basis. Mr. Fano's family talked with him from Southern California a number of times and had a visit. After Mr. Fano's death, his phone call records were transcribed. EBR has the kind of phone system that is used in most prisons and jails, and all inmate calls with the exception of legal calls are recorded and can be listened to in real time or at a later time, at the convenience of the facility. If either the security staff or the mental health staff at EBR had been sufficiently concerned about assessing Mr. Fano's condition, they could have easily listened to portions of a few of his phone calls with family. They would have found that he was distraught, hearing voices, and suffering from being kept in isolation. They would have also found that he frequently said, "I can't do this," a reference to suicide intent.

7. The phone records demonstrate the degree to which he does not understand his surroundings in the jail. On the 28th of January the recording of his phone call with family include, "I can't stay here. I am going crazy." That same recording, on pg. 5, at lines 4-6; "I'm not eating... I can't sleep... I can't do anything." On the same recording at pg. 9, line 8-10; "...I'm in bad shape. I'm hearing voices..." It is important to note that this last phone call is 10 days after Dr. Blanche noted that Mr. Fano was likely not suffering from serious mental illness and only a few days after Dr. Blanche had stopped his anti-psychotic medications.

8. These phone recordings demonstrate that Mr. Fano's family was deeply concerned for him, supportive and trying to help him in the best ways they could. His father, Carlos Fano, spoke with him by phone, apparently on Christmas Day, 2016. Also on Christmas, Mr. Fano was able to call his mother and speak with her and his sister Vanessa. Vanessa was also able to identify family letters to and from Mr. Fano while he was in EBR. Mr. Fano's family was quite religious, and so was he. On the January 28 phone call, the family's last contact with Mr. Fano before his death, a family member – likely his mother – tells him, "try to participate in church services," to which Mr. Fano replies, "There aren't services here."[3] There is reference to a chaplain at EBR visiting N01 and N02 once a week, but if a chaplain had visited Mr. Fano, even occasionally, it seems likely he would have mentioned to his family in this kind of conversation, and he did not. There is no record at EBR of a chaplain ever talking with Mr. Fano.

9. It is also apparent that the family considered the best alternatives for Mr. Fano with regard to his release options. They found out that they could bail him out somewhat sooner than his scheduled release date but rejected that option because they thought it would place him in an impossible situation in which he would have to fly back from Southern California to Baton Rouge for various court appearances and that he would likely be overcome with the same kind of anxiety that led him to get off the bus in Baton Rouge in the first place, and that the end result would be a warrant for his arrest for failure to appear. One member of his family can be heard explaining that to him in the earlier phone call (118721402-3480, pg. 4, lines 12-20), "can't bail you out because you'd have to keep flying out here and going through the whole anxiety thing," … and that "they'll put out a warrant for you." In light of Jonathan Fano's severe mental health history and the fact that he was in bad shape and actively hallucinating at the time, their reasoning was realistic. In his condition, it would have been unlikely for him to successfully navigate cross country trips to return to court. A missed

[3] It should be noted when inmates cannot be taken to a congregate area such as a chapel for religious services, that is standard correctional practice to have chaplains provide religious counseling or services at cell fronts.

court appearance would equate to a bench warrant for failure to appear. There was also the chance that Mr. Fano would attempt to travel and would have another episode similar to what happened in downtown Baton Rouge, or perhaps he would have been taken off an airplane under arrest. Any incident of that kind, or perhaps a bench warrant, could have resulted in additional charges against Mr. Fano and further entangled him in the criminal justice system. Thus, weighing the alternative of bail and further required court appearances against leaving this situation and waiting for Mr. Fano to reach his release date, the family chose the latter course of action as being in Jonathan Fano's best interest. Importantly, the family was also following the advice of Jonathon Fano's attorney, from the Public Defender's Office, who counseled the family not to bail him out, for the same reasons explained above. Hindsight is 20/20 and after Mr. Fano's suicide, it is easy to criticize the family for not deciding to make bail and get Mr. Fano out of EBR. However, while the family knew that Mr. Fano was not doing well and was complaining about isolation and lack of medication, they were being assured -falsely, it turns out- that EBR was providing appropriate mental health treatment and they had no way to know of EBR's almost total abdication of their responsibility for Mr. Fano's welfare and safety.

10. If EBR staff did not want to take the time or trouble to review some sample of Mr. Fano's family phone calls in order to help determine his condition, they had other obvious avenues to find out what was happening with Mr. Fano. The security staff charged with making the rounds on N01 and N02 could have and should have noticed that Mr. Fano was not communicative, looked upset and with some frequency did not take his medication. If a security staff member had tried to talk with Mr. Fano, one of two things would have happened. Either he would not have responded and been uncommunicative with them, or he would have responded and talked to them more like he talked with his family, acknowledging that he was hearing voices and distraught. In either case, the security staff member would have known that there was a serious problem and that he needed attention from the mental health staff. EBR also should have known about Mr. Fano's condition, in some detail, from mental health staff. After all, this was an inmate who had been sent to a local hospital in November after attempting suicide and it had been documented that he was hearing voices and distraught.

11. Courtney Eichelberger was the CorrectHealth social worker assigned to do rounds on M and N units and she testified that she felt like she did those rounds every day. She added that it felt like she was there a lot. She also testified that those rounds meant that she went completely up and down the tiers (Eichelberger deposition, pgs. 40-41, lines 18-10). Ms. Eichelberger also testified that when she was doing the rounds on those units, she was checking on the wellbeing, needs and concerns of the inmates and that if they were on suicide watch or mental health observations she would be stopping to see and visit with them (Eichelberger deposition, pg. 41, lines 12-19). From the time Ms. Eichelberger began working for CorrectHealth at EBR on January 23, 2017, until his suicide, was ten days. From Ms. Eichelberger's testimony, it would appear that she would have made the rounds N-02 on a daily or almost daily basis and checked on Jonathan Fano's condition and even stopped and visited with Jonathan Fano. That is not what happened. Based on EBR log books, from Jan. 23 to Feb. 2, 2017, Ms. Eichelberger visited N unit a total of one time, on 1/26 (EBRSO 001250). There is no documentation of any contact between Ms. Eichelberger and Mr. Fano prior to his suicide and she testified that she never heard of Mr. Fano until after his suicide (Eichelberger deposition, pg. 27-28, lines 19-1). Ms. Eichelberger also testified that she did not know if she had received the CorrectHealth policies when she was hired or whether she

ever had read them (Eichelberger deposition, pgs. 59-60, lines 19-4). In spite of Ms. Eichelberger's incorrect assertion of daily or almost daily rounds on M and N units that she testified to, she said that she did not know about any programs on those units and that she did no group sessions and no extensive counseling for inmates on those units (Eichelberger depo, pg. 38, lines 10-22).

12. In reality, EBR was on notice that Jonathan Fano was an acute and imminent suicide risk. EBR knew that because the inmates on N-02 were well aware that Mr. Fano was severely mentally ill and was actively wanting to kill himself, and some of those inmates told staff. In January and the beginning of February, Mr. Fano was housed in a cell at the far end of the N02 unit, next to the shower. Thus, every inmate who was released from his cell to shower had to walk past the front of Mr. Fano's cell. It was common knowledge among the inmates on N02 that when inmates walked past Mr. Fano's cell front he would ask them for a razor in order to kill himself. At his depo, Mr. Hinton testified that he was housed on N02 and that he was a "hall man" (inmate worker, or trustee, charged with cleaning the public areas of the unit). Mr. Hinton said there were several mental health inmates who were out of their minds and should not have been on N-02 (Hinton deposition, pg. 42, lines 10-23). He further said that Mr. Fano was one of those mental health inmates and that he and a few other inmates told deputies about Mr. Fano and told the deputies that Mr. Fano should have been moved (Hinton deposition, pgs. 46-47, lines 13-4). Mr. Hinton testified that Jonathan Fano asked for a razor in order to kill himself and that Mr. Hinton told deputies, including Deputy Monroe and, he believed, Deputy Brown as well (Hinton deposition, pg. 48-50, lines 13-5). Later in his deposition, Mr. Hinton had remembered that he had told Deputy Brown and Deputy Monroe about Mr. Fano wanting to kill himself (Hinton deposition, pgs. 132-133, lines 13-1). Mr. Hinton said that the inmates on N-02 knew that Mr. Fano had tried and failed to commit suicide when the ligature broke (Hinton depo, pgs. 72-73, lines 21-15). Mr. Hinton testified that inmates also told medical staff about Mr. Fano being suicidal (Hinton deposition, pg. 71 lines 1-17), and that he personally heard inmates tell nurses about Mr. Fano at least twice (Hinton deposition, pg. 133, lines 14-23). He also said that other inmates also knew that Mr. Fano was asking inmates for a razor and that he said he "couldn't take it" (Hinton deposition, pg. 75 lines 1-4).

13. Former inmate Frank Brooks was housed on N02 at EBR from somewhere between January 24 and January 27 until well after Mr. Fano's suicide. At his deposition, Mr. Brooks testified that a Spanish inmate in a cell at the end of N-02 asked him for razors and that he told the deputies and also told one of the medical staff, Ms. Granger (Brooks deposition, pgs. 33-34, lines 12-12). Mr. Brooks also testified that, in addition to the razors, he remembered "the Spanish guy" having what Mr. Brooks referred to as "mental complications" because "his conversation wasn't normal" and he was talking to himself and also talking as if he was conversing with Mr. Brooks and a few other people at the same time (Brooks deposition, pg. 36-37, lines 6-14). In Mr. Brooks sworn statement, he was more specific, stating that Mr. Fano was, "asking for a razor blade every time I saw him", and that Mr. Fano was, "Talking to himself, saying things out loud to no one … like he was hearing and talking to voices in his head."

14. Inmate McNeely, in cell 22, and the inmate in cell 23, Bobby Earl, described Jonathon Fano as crying often and said so to the Sheriff's investigator, Sgt. Henning, in the aftermath of the suicide. Many inmates on N02 knew Mr. Fano was seriously mentally ill and asking for a razor in order to kill himself.

15. After Jonathon Fano's suicide, notes were found in his cell indicating he may have been targeted by other inmates for food and for sex. It is not known when those incidents occurred and there was no follow-up by the Sheriff's investigators. The relationship between his victimization and his suicide will likely never be determined but the victimization likely could have been prevented had EBR followed the PREA requirements correctly at his intake. Also, had even one thorough cell search been completed in the three months Mr. Fano was on N01 and N02, the notes would have been discovered and staff could have worked with any ongoing threats or remaining fears. None of that happened.

K. Required Cell Checks Might Have Saved Jonathan Fano's Life

1. Cell checks are one of the primary defenses against inmate suicides in prisons and jails. That is, cell checks (also called security rounds, welfare checks and other less frequent names; at EBR they are most frequently referred to just as "rounds" but are called "cell checks" throughout this report) are standard in correctional facilities. They serve two crucial and co-equal but quite different purposes. One of the purposes is security. When an officer looks into a cell, he or she is looking for any evidence of a security problem. Is there a weapon in sight, or homebrew, or evidence of tampering with the cell or with the bars? The other equally important purpose of the cell check is inmate welfare. Is the inmate obviously injured? Is there blood on the floor, or vomit? Does the inmate appear to be hallucinating? Is there a suicide attempt in progress?

2. It is not possible to satisfy these two objectives by walking past a cell at a slow trot. It is necessary to go to the cell front and stop and look in the window in the cell door (unless it is an open barred cell front) and spend perhaps three to five seconds or more making sure that everything in the cell appears to be normal. Many agencies teach staff that the key three-word mantra for cell checks is, "flesh and movement". That is, if you cannot see flesh, then you may have to wake the inmate so that you can be sure that the lump under the covers is not a dummy covering up an escape attempt. Similarly, if you cannot see movement you must stay at the cell front until you see indications of breathing.

3. Cell checks have been documented to prevent suicides. Although it is not directly related to Mr. Fano, LPN Danielle Thomas provides an excellent and typical example in her deposition in this case of how a cell check can save a life during a suicide attempt. Ms. Thomas described coming across a female inmate who had tied a towel or blanket to the cell bars and was hanging until Ms. Thomas held her up with her weight off her neck until staff cut the woman down (Thomas deposition, pgs. 40-41, lines 18-12). Cell checks are best conducted on a staggered schedule so that if they are required every thirty minutes, then it is usual to sometimes do twenty-two minutes and perhaps the next time twenty-nine minutes and continue to keep the schedule somewhat varied so that inmates are not able to time the officers' rounds. In general population areas cell checks are typically required every thirty minutes to every sixty minutes. For segregation housing and other specialty units, fifteen minutes to thirty minutes is typical and suicide watch is usually in the ten to twenty-minute range with fifteen minutes most common.

4. An additional advantage of cell checks with regard to suicide prevention is that they guarantee frequent opportunities for inmates to talk to staff, make requests, or let staff know if they are in distress. Since inmates know staff will come to their cell door approximately

every thirty minutes (or fifteen if on suicide watch) an inmate can use that opportunity to talk to staff without alerting the entire unit.

5. Warden Grimes testified that cell checks were required every fifteen to thirty minutes, on a staggered schedule. That does not make sense. Since N01 and N02 combined segregation inmates with suicide watch inmates, thirty-minute intervals would be inadequate for the suicide watch inmates. A fifteen-minute interval would be very difficult for all of M, N01 and N02 (Sgt. Cage testified that it required 30 minutes to complete one round of cell checks on N01 and N02). It would have made better sense, even if just for the purposes of cell checks, to have the suicide watch inmates in one area where they could be monitored on a fifteen-minute staggered schedule.

6. The biggest problem with cell checks on N01 and N02 was that the staff too often did not conduct them. That is not an unusual problem. When staff walk through a living unit, conducting cell checks, and find time after time that nothing is amiss, particularly at night, staff are tempted to become complacent and make a log entry but simply not do the required cell checks.

7. In earlier times, the only safeguard against that kind of staff negligence was for supervisors or managers to visit the living units and check the unit logs and also see if the staff assigned to the unit were engaged in doing cell checks. That could be difficult, because in some facilities the frontline staff would send signals to each other indicating that a manager or supervisor was coming around. That made it difficult to determine if staff were documenting cell checks in the logbook but not actually conducting them. That has changed dramatically with the widespread use of security cameras. Today, a supervisor can look at the logbook and the documentation of cell checks and then look at the video footage from the security camera or cameras showing the living unit corridor. Either the Deputy is visible walking down the corridor when he or she has documented the cell check on the logbook, or there is no staff member walking the corridor at that time and the log book entries are false. The security camera footage also allows supervisors and managers to make sure that the staff members doing cell checks are actually stopping at cell fronts long enough to realistically notice a problem if one exists. At EBR, there is compelling evidence that Deputies frequently failed to conduct the required cell checks on N01 and N02. Numerous inmates testified to that in deposition or provided declarations under oath to that effect. One of the several disciplinary actions taken against Sergeant Cage stated that one of her subordinates had failed to make required cell checks continuously for a period of six hours, and that she had not recognized the problem.

8. There should be no argument about whether staff regularly performed cell checks or not because the case record provides direct physical evidence. That evidence is consistent with inmate accounts of deputies failing to perform cell checks, sometimes for extended periods of time. The physical evidence consists of video footage from the security camera provided by EBR and showing the N02 corridor the evening prior to Mr. Fano's suicide and then showing that same corridor on February 2, 2017, the day of his suicide. In general, the video begins at 8:40 PM on February 1 and then continues until after the suicide on February 2. There are some relatively short gaps where video was not provided and there are some other times when there was video but it did not show enough of the area in question to be conclusive. In most cases the time stamp on the video could be matched against logbook

entries where staff had entered documentation purporting to show that they had completed cell checks.

9. From 8:40 PM the night before the suicide until 5:27 PM on February 2, shortly before Mr. Fano was discovered hanging in his cell, there were 34 log entries that could be compared to video footage of the N02 corridor. On 16 of those 34 log entries, or just one short of half of them, staff have recorded cell checks being completed but the video footage shows no staff member walking the N02 corridor, or even on the N02 corridor, during the timeframe covered by the log entry. That would suggest that approximately half of the log entries during this 18- or 19-hour period did not occur. The actual situation is likely somewhat worse than that, however, for of the 18 occasions on which there was a log entry and one or more deputies visible on the video on the N02 corridor, five of those 18 occasions were deputies accompanying a nurse on medication pass and seven of those occasions were at mealtime and the deputies were on the unit because they were distributing food trays to the inmates. If those 12 occasions are taken out of the equation, then there were 22 remaining times where there was a log entry of cell checks being completed and video showing the corridor during that same time frame. The video only showed deputies on the corridor for six of those twenty two occasions, or approximately 30% of the times required to conduct cell checks.

10. It could be argued that the time stamp on the video footage may be inaccurate, accounting for the lack of congruity between the logs and the video footage. However, the time stamp on the video footage matches the various reports at the time Mr. Fano was found hanging in his cell, eliminating that possibility. A second potential concern would be that the deputies were conducting the required cell checks but that they were doing so on the catwalks behind the cells, which would not be visible on the video. There are a number of reasons to reject that possibility, including that the catwalks were dirty and awkward to navigate and that the windows from the catwalks into the back of the cells were badly scratched or otherwise damaged in a number of cases so that a staff member could not easily see into the cell and, in any case, would not have a view of the entire cell. All of that is perhaps less than relevant because Warden Grimes, at his deposition, testified that he had issued an order that cell checks were not to be done on the catwalks, and if staff ever did conduct cell checks from the catwalks, they were obligated to note that fact when documenting the cell checks. Finally, it may also be tempting to hypothesize that the limited timeframe that was examined, an 18 or 19 hour duration over two days, might have involved only one or two deputies who logged cell checks that did not appear on the video footage. That was not the case. The sixteen occasions in which there is a log entry but no video evidence of any cell checks, included two deputies, two corporals, a sergeant, and a lieutenant.

11. Former inmate Emanuel Jones overlapped with Mr. Fano on N02 and his sworn statement includes a succinct summary of this issue. Mr. Jones wrote, "the day Fano hanged himself, Dep. Brown did not do his count until 5:30. I do not know what he wrote in the log, but if he had done his roll call at 5 like he was supposed to, Fano would not have been able to hang himself when he did."

L. EBR Failed to Administer Prescribed Medications

1. When Mr. Fano was arrested and taken to EBR, he had been prescribed anti-psychotic medication for three or four years. Dr. Blanche initially prescribed an anti-psychotic for him

but then tapered it off and discontinued it entirely just prior to Mr. Fano's suicide. However, even when the prescription was in force, Mr. Fano missed his medications 57 times. Of those 57 occasions, there was documentation as to why his medications were missed on only six of those times. The other 51 occasions are unexplained.

2. Once again, this is not a new problem at EBR or one for which EBR had had no notice or warning. The HMA study had found that medications were missed on 22% of scheduled occasions. Then, rather than correcting the situation, some six months later Mr. Fano is in EBR and his medications are missed over 30% of the time.

M. The EBR Suicide Prevention Policy and Procedure

1. One of the most crucial issues in any jail is suicide prevention because it has been well known for some time that suicide is the single leading cause of death for jail inmates. Thus, most jails have detailed and comprehensive suicide prevention policies and procedures.

2. In 2016 and in 2017, the EBR suicide prevention policy and procedure (EBRSO 000579) was a total of one page and was hopelessly inadequate. The policy states that an inmate on suicide watch will be placed in a single cell, in itself contrary to safest practices with suicidal inmates, on M or N units. It does not say which of those three living units will be used, so that suicide watch inmates were scattered. That makes staff observation and staff awareness more difficult for no good reason. The policy does not specify how frequently observation must be made and does not require suicide watch logs. Those are consensually accepted standards throughout corrections. The policy specifies that phone use for the inmate will be dictated by the location of the cell the inmate is placed in, rather than determined by some standard for all suicide watch inmates or by clinical decision. The policy does not specify who can release an inmate from suicide watch. It does not require or discuss any follow-up once an inmate is removed from suicide watch. There is no mention of the frequency of clinical visits or assessments for those inmates on suicide watch. That is just a sample of the crucial missing elements in this policy. Importantly, even as minimal as the policy was, it was not followed. The policy requires that when the medical department believes an inmate may be suicidal, the medical department will email a suicide watch notification to classification, to the disciplinary board, to the chief of security, and to the security shifts. When Mr. Fano was placed on suicide watch, that did not happen.

J. Solitary Confinement and Isolation Housing

1. In 2016, the U.S. Department of Justice issued its final report on the use of restrictive housing in correctional facilities, in response to a Presidential request for a review of the overuse of solitary confinement. Based on an extensive review, the report states that as a matter of policy the Justice Department believes strongly that segregating inmates from the general population is a practice that should be used rarely, applied fairly, and subjected to reasonable constraints. The Justice Department goes on to state that best practices include housing inmates in the least restrictive settings necessary to ensure their own safety as well as the safety of others and that restrictions on an inmate's housing serve a specific penological purpose and are imposed for no longer than necessary.

2. The report notes that when an inmate must be segregated from the general population, the inmate should be housed in safe and humane conditions. In the report, solitary confinement

or restrictive housing is defined as involving removal from general population, placement in a locked room or cell with inability to leave that room or cell for 22 hours or more a day. Jonathan Fano's incarceration on N01 and N02 met and substantially exceeded those criteria as he was unable to leave his cell for more than 23 and a half hours per day. It is clear from even the overview in the US Department of Justice report that EBR was far from compliant with these guidelines in the case of Jonathan Fano. His segregation conditions were not humane and he was not kept in segregation for the minimum time necessary. In fact, Mr. Fano was at EBR for approximately 90 days until his suicide and for all but two of those days, he was in isolation under extremely punitive conditions. Warden Grimes testified at his deposition that inmates sentenced to disciplinary segregation are limited to 20 days per month in isolation and even then there is a requirement that after 10 days in isolation they must be taken out of isolation for a day before they can be placed back for an additional 10 days. It makes no sense to limit isolation to 10 days at a time and 20 days per month, at a maximum as a sanction for inmates committing serious infractions, but then place no limit on the amount of consecutive days in isolation for inmates with serious mental illness. It is that latter group of inmates, those with serious mental illness and or suicidal tendencies, that will predictably suffer more serious effects from isolation than most general population inmates who have been sent to isolation as their punishment.

3. Warden Grimes testified that everyone in administrative segregation for mental health issues comes in front of an interdisciplinary board on a monthly basis that includes the Warden, the top staff, the EBR psychiatrist, and other health and mental health staff in order to reassess each individual, and that that procedure had started before CorrectHealth began at EBR and that Warden Grimes had initiated that review board (Grimes deposition, pgs. 47,-48, lines 10-6). That may have been a theory or a plan but it was not what was done with Mr. Fano. He was not seen by that board in November although he was in segregation housing for most of that month. He was not seen by the board in December although he was in segregation housing for all of that month. In January, Mr. Fano was again not seen by that board. In fact, he was never seen by that board although it was supposed to operate as a major safeguard against leaving an individual in administrative segregation for too long. The Warden also testified there was a second safeguard against an individual inmate getting "lost" on the segregation units, the "lockdown board," which also reviewed all lockdown inmates on a monthly basis. Mr. Fano was not seen by that board in November or in December, however. He was finally reviewed by that Board in January and there is nothing to document that review except a notation that he was to "remain," but without explanation except that he was categorized as "medical/suicide"(EBRSO 02149). In reality, at the time of that review, Mr. Fano had been off suicide watch for two months. Considering both boards, Mr. Fano should have been reviewed six times during the time that he was locked up on N01 and N02 but these safeguards did not operate for Mr. Fano.

4. Based on prior medical records and the deposition of Dr. Gregory Doane, when Mr. Fano was arrested and taken to EBR, he had been prescribed anti-psychotic medication for three or four years. Dr. Blanche initially prescribed an anti-psychotic for him but then tapered it off and discontinued it entirely just prior to Mr. Fano's suicide. However, even when the prescription was in force, Mr. Fano missed his medications 57 times. Of those 57 occasions, there was documentation as to why his medications were missed on only six of those times. The other 51 occasions are unexplained. Once again, this is not a new problem at EBR or one for which EBR had had no notice or warning. The HMA study had found that medications were missed on 22% of scheduled occasions. Then, rather than correcting the

situation, some six months later Mr. Fano is in EBR and his medications are missed over 30% of the time.

K. Violations of State and National Correctional Standards

1. The HMA study included a detailed analysis of various health and mental health standards promulgated by the NCCHC. As HMA made clear in their report, there were numerous areas where EBR was in substantial violation of those NCCHC standards.

2. Similarly, there have been a number of issues discussed in this report in which I have opined that the practices of EBR in general and the specific performance of EBR and its staff with regard to Mr. Fano, failed to meet national correctional standards. The EBR method of housing mentally ill and suicidal inmates is an excellent and obvious example.

3. There are only two currently promulgated and maintained sets of written national standards for correctional facilities. The first of these is published by the ACA and covers jails and prisons very broadly with standards ranging from sanitation to security to inmate programs to suicide preventing, and much more. The second set of written national standards are the NCCHC standards, referred to above. Those standards are substantially more detailed than the ACA standards but cover health and mental health issues exclusively (including pharmacy, dentistry, etc.). Neither set of written national standards is binding upon counties or states unless a particular jurisdiction has chosen to adopt that set of standards. Thus, for most counties and most states, they do not have force of law but are influential, particularly in the case of the NCCHC standards.

4. The situation with state jail standards is different. Most states have state jail standards specific to that state, although some states do not. In Louisiana, the state jail standards are found in Title 22, Part 3, Subpart 3, and are called "Minimum Jail Standards." Those standards have been adopted by the state Legislature, signed by the Governor and do have force of law.

5. Section 2705G of Louisiana State Jail Standards requires that the method and frequency of supervisory review of staff must be specified and documented. There is nothing in the documents produced by defendants in this case that would appear to meet that state requirement.

6. Section 2909E states, "inmates shall have continuous access to emergency healthcare by trained personnel and professional medical attention whenever required." Mr. Fano did not have continuous access to emergency healthcare during the two months following his first suicide attempt at EBR and had no access to either emergency healthcare or professional medical attention after his second suicide attempt.

7. Section 2909H requires that new inmates be asked during booking about the state of their health, medications taken and any health problems, with immediate referral to a physician where indicated. There was no serious inquiry about Mr. Fano's health history or his medication history when he was booked into EBR.

8. Section 31111A requires active outdoor recreation for all inmates for one hour per day, three times a week, where possible. Mr. Fano spent more than three months at EBR and it appears

that he never had so much as one hour of outdoor recreation in three months. Further, it is standard practice in correctional facilities that when a particular jail has no outside recreation yard or has no outside recreation area that would be secure for certain inmates, then inmates are given some recreation time indoors, whether in a gymnasium or some other large area where they can move about, perhaps with windows or sky lights open, etc. The important point is when this standard cannot be met, some reasonable alternatives must be arraigned and then maintained. That was simply ignored at EBR for N01 and N02 inmates, who were out of their cells for fifteen minutes or thirty minutes a day, and that time included shower time. Their "recreation" was limited to walking up and down the corridor. That generally accepted correctional practice is embodied in section 3111B, "inmates shall be provided with some form of indoor recreation activity on a daily basis." EBR made no attempt to comply with this state regulation. Walking to a shower and back is not "recreation".

9. Section 3305E states, "inmates may be involuntarily confined in their cells a maximum of 12 hours in any 24 hour period except as required for security reasons." There was no good security reason why Jonathan Fano had to be confined in his cell for 23.5 or 23.75 hours per day. He was not a danger to other inmates and he was not a danger to staff. He was not classified as on suicide watch so that he was not an imminent danger to himself. He was not classed as a potential victim so he did not need to be kept away from other inmates. Although both of these determinations by EBR are incorrect (that is, his PREA classification should have been "potential victim," and he should have been seen as an ongoing suicide risk), based on his classification by EBR, they were in constant violation of this standard with him.

10. Section 3307A requires that inmates have continuous access to communication from their housing areas to a staffed control station. Newer jails and prisons are typically built as modular or podular facilities and in those designs, staff can see all or almost all of the cells from a control area. In jails and prisons that use direct supervision, staff members are stationed full time inside the living units with the inmates. In older, linear facilities such as EBR, it is common to have a buzzer system or an intercom system or something similar, so that an inmate in distress or otherwise needing immediate staff attention, can immediately communicate with a control room or other staff station. EBR had none of that for the inmates on N01 and N02. Inmates talked about having to "rack the bars" in order to get staff attention when there was an urgent or emergency matter in that housing area. "Rack the bars" means that the inmates shake the cell doors to make enough noise that staff will hear them. Yelling and kicking the cell doors are also often used by inmates in those situations, but that does not substitute for a communication method providing continuous access, as required by the Louisiana state standard.

11. Section 3307C provides that protective custody inmates shall have equivalent conditions to the general population. That issue was discussed in this report and it should be clear that EBR makes no attempt to meet this state standard. Inmates on protective custody are housed with disciplinary segregation and, in general, are subject to the conditions governing those inmates in disciplinary segregation.

12. Section 3305C requires that inmates be logged into and out of the institution when entering or leaving for any reason. That is closely related to section 2705D which requires, "a log shall be kept of all persons entering or leaving the jail." While these two requirements do not apply to Jonathan Fano, they do serve as examples of how badly EBR was and is

operated. For a jail, these requirements are little more than common sense. Yet, when Lamar Johnson died in his cell at EBR, EBR was surprised because they did not have him listed as part of the population at the jail and thought he had already been discharged.

VI. Summary and Conclusions

A. EBR, the Parish, CorrectHealth and the prior medical/mental health provider were all on notice that EBR could not safely house mentally ill inmates. They were on notice because EBR officials and Parish officials testified to that effect, at length and in detail in 2015, at one point describing the situation as "an emergency", and for mentally ill inmates, "life or death".

B. In mid 2016, a comprehensive report from an independent consulting company provided a lengthy analysis of the medical and mental health facilities, services, and operations at EBR. That independent analysis confirmed that EBR needed to develop or build a mental health unit and could not safely manage mental health inmates in the current state of EBR. Both medical/mental health providers (pre Jan.1, 2017 and post Jan.1, 2017) had access to that report as did Parish officials.

C. EBR, the Parish and the medical/ mental health providers knew the EBR could not come close to providing the quality of metal health care that was available in the community, and that it was dangerous to continue to house the seriously mentally ill at EBR, and to do so would predictably lead directly to long-term harm and even death for those inmates.

D. EBR, the Parish and the medical/mental health providers made no substantial attempts to eliminate or even mitigate the predictable harm to seriously mentally ill inmates at EBR and were callously unconcerned about those risks. Jonathan Fano's suicide death was a direct and proximate result and his family is left to cope with what was almost certainly a preventable tragedy.

E. When CorrectHealth took over health and mental health service at EBR on Jan. 1, 2017 they might have saved Jonathon Fano's life had they advocated to EBR security for medically appropriate ways to deal with the mentally ill. Instead, they continued with the discredited and dangerous practices that had been in place at EBR. That included placing individuals with mental illness in solitary confinement, minimal clinical contacts with the inmates in solitary confinement on N01 and N02, no meaningful reviews of those individuals, no programs for them and no movement toward establishing a functional mental health unit. In spite of a Jan. 3 report that Mr. Fano was hearing voices and suffering from anxiety and depression, and more recent information that he was not eating or sleeping, CorrectHealth staff member Cathy Schley saw Mr. Fano on Jan. 11 and decided he was likely faking or exaggerating. His family knew better and most of the inmates on N02 knew better but CorrectHealth also failed to respond to any of that information and their failures ultimately doomed Jonathon Fano's young life.

Jeffrey A. Schwartz, Ph.D.
January 9, 2020
At Campbell, CA

End-

Jeffrey A. Schwartz, Ph.D.
January 9, 2020
At Campbell, CA

-End-

APPENDIX A

Jeffrey A. Schwartz, Ph.D.

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SUMMARY

Thirty years experience in criminal justice management coupled with a psychology Ph.D. in research methodology. Detailed, hands-on experience with police, prisons, jails, community corrections; adult and juvenile; local, state, federal and foreign correction agencies. Development of innovative training programs and new approaches to training methodology. Planning for "turnaround management" and culture change in troubled institutions and agencies.

PROFESSIONAL EXPERIENCE

LETRA, Inc., Campbell, CA (1972 - present), A non-profit training and research organization, serving criminal justice and other governmental agencies, business and industry.

Founder and Chief Executive Officer:
All phases of corporate and fiscal management, supervision of professional staff, consultants. Policy development and procedures for emergency preparedness, use of force and conflict resolution. Design of new training programs and training of trainers.

RICHMOND POLICE DEPARTMENT, Richmond, CA (1968-1976)

Administrative Consultant to the Chief of Police:
Organizational development, research, program evaluation, new training programs and grants. Developed first generalist police crisis intervention training program in the U.S.. Planned and organized innovative department-wide juvenile diversion project, used as state model. National research on female and minority employment in policing.

PALO ALTO VETERAN'S HOSPITAL, Palo Alto, CA (1969-1971)

Chief of Program Evaluation Unit:
Founded, organized and managed new applied research unit in large medical/psychiatric teaching hospital. Developed research and statistical strategies for evaluating effectiveness of clinical programs. Served on Hospital Director's Executive staff.

EDUCATION

1960-1964	Western Reserve University	B.A. Chemistry and English Literature.
1964-1965	Toledo University	Graduate work: Psychology
1965-1968	Denver University	M.A. & Ph.D. Experimental Psychology (Research Methods, Learning, Statistics)
1968-1969	Palo Alto Veteran's Hospital	Internship: Clinical and Community Psychology

CORRECTIONS EXPERIENCE (representative sample)

National Institute of Corrections: Thirty years experience working with NIC. Conducted two large national management training programs over three years. Developed original curriculum, innovative training methodology, trained 500 managers from all areas of corrections from all 50 states in a residential 7-day, intense corrections-specific management skills training program. Administrated all aspects of these projects. Project Director for more than 10 major NIC grants / cooperative agreements; technical expert on more than 25 NIC technical assistance projects from all four NIC operating Divisions; authored 3 book length NIC publications. Helped plan new NIC courses and evaluated NIC operating procedures.

Shelby County, TN (Memphis) Jail: Comprehensive operational review of deeply troubled large jail system after Federal Court found the county in contempt of all five major elements of consent decree (2000). Developed plan to cure contempt findings, drafted response to Civil Rights Division of US DOJ to avoid second1983 suit, worked on transformation of jail to direct supervision and on population management, use of force, inmate grievance system, management training and practices. Achieved discharge from Federal Court supervision in 2005 and from DOJ supervision in 2009.

California Youth Authority (CYA): The development of Conflict Management and Crisis Intervention procedures in all Youth Authority institutions; training and procedures for the management of hostage situations; training of trainers. LETRA's Crisis Intervention training program has been required by policy of all CYA institutional staff and in use for over 15 years, and LETRA's Emergency Preparedness course was in use state-wide for over ten years.

Montana Department of Corrections (DOC): After the maximum security unit riot and hostage situation at the Montana State Prison in Deer Lodge, in 1991, selected by NIC to head the seven person Administrative Inquiry Team commissioned to investigate the events leading to and surrounding the riot. Coordinated the writing of the Inquiry Team Final Report ("Riot at Max") and managed extensive media contacts for the Inquiry Team.

Michigan DOC, Hawaii DOC, Alaska DOC: Initiated state-wide training programs in each state on institutional crisis intervention. All three State DOC's continued to provide this training to all or almost all institution staff for many years.

Pennsylvania DOC: After Camp Hill riots, conducted assessment of Department's emergency response capacity, developed plan to increase preparedness including recommendations for specialized equipment, staff, etc. Conducted administrative policy seminar, tailored emergency training curriculum to department's needs, trained cadre of mid-managers to deliver emergency preparedness training at all 16 institutions to both management and line/supervisory staff and developed format for new institutional emergency plans.

Nebraska, Iowa, Wyoming, Oregon, Kentucky, North Carolina, Missouri, Kansas, Florida, Delaware, North Dakota, Hawaii, Nevada, Arkansas, Vermont and New Hampshire DOC's, the Omaha, Jacksonville, Greenville and Boise jail systems: Emergency Preparedness. Typically began with security analysis and evaluation of existing emergency plans and procedures, review of emergency policies, leading to adaptation of LETRA's detailed, comprehensive and generic ("all risk") emergency system. Provided Emergency Preparedness training for all staff at all institutions on new emergency system by training and certifying department instructors.

Hawaii DOC: Created new Use of Force policy, then developed curriculum to train all staff to new policy. Prepared Department staff as instructors so Department would be self-sufficient. Achieved substantial reduction in allegations of improper use of force. Similarly adapted LETRA's model use of force policy and training for state DOC's in Oregon, New Mexico, Shelby Co. Jail.

Correctional Services of Canada: Crisis Intervention and Conflict Resolution work at Stony Mountain Penitentiary following riot and murder of two staff members. Developed Conflict Resolution program (in English and French) for all Regions of Penitentiary Service. Revised and expanded emergency policies governing crisis management at all Federal institutions in Canada.

POLICE CONSULTATION EXPERIENCE (representative sample)

FBI National Academy, Quantico, Virginia: Presented two seminars on Domestic Crisis Intervention to police executives from largest 50 police departments in U.S. LETRA was the first outside group (non-FBI) to be invited to present an entire course at the FBI Academy.

Richmond, California, Police Department: Developed new 40-hour training program for generalist patrol officers on child and juvenile issues. Course ranged from gangs to drug abuse to battered and neglected children. All uniformed officers and detective trained within one calendar year.

Sacramento, California, Police Department and Sheriff's Office: Long-term project to train trainers in Crisis Intervention. Over 1500 patrol officers trained in LETRA's Domestic Crisis Intervention during an 18 month period. Evaluation showed 40% reduction of officer injuries, reduction in time spent on disputes. Similar projects in Rochester, NY; San Jose, CA; and other police agencies.

COLLEGE/UNIVERSITY TEACHING EXPERIENCE

Denver University, San Francisco State University, San Jose City College, University of California at Santa Cruz, Guest Lecturer at Stanford Law School. Psychology courses taught: Learning, Theory of Measurement, Educational Psychology, Introductory Statistics. Criminal justice courses: Correctional Management, Police Supervisory Training, Training for Trainers, etc.

EXPERT WITNESS (Plaintiff and defense-side experience)

Use of Force (Police and Corrections); Operation of Correctional Facilities; Failure to Protect (Staff Sexual Misconduct with Offenders; Suicide; etc.); Emergency Preparedness and Emergency Response (Prisons and Jails); Crisis Intervention (Police, Probation, Parole, Jails and Prisons)

Currently a Federal Court Monitor On a Los Angeles Jails class action consent decree on use of force; also Federal Court Monitor, use of force consent decree, San Bernardino County Jails.

Class Action and related cases: Corrections expert in class action by Southern Poverty Law Center and Special Litigation Section of DOJ resulting in 2013 Consent Decree against New Orleans Jails; Corrections expert for Manhattan U.S. Attorney's Office in CRIPA investigation of adolescent conditions, Rikers Island; Invited testimony before Citizens' Commission on Jail Violence (CCJV), Los Angeles Jails; Federal Court security expert, consent decree on conditions, Virgin Islands Jails;

CRITICAL INCIDENT REVIEWS ("after-action reports")

Camp Hill (PA) riots; Hurricanes Katrina and Rita and the LA DOC; Hostage taking at Delaware Correctional Center; "Riot at Max" at Montana State Prism; Wyoming Penitentiary carbon monoxide poisonings; Southern Ohio Correctional Facility (Lucasville) riot.

AWARDS, PUBLICATIONS AND INVITED ADDRESSES

NDEA Fellow in Graduate Psychology. Presented invited addresses at ACA, APPA, AJA, CPPCA, IACP meetings, State Correctional Associations. Published numerous articles and chapters on corrections, research methodology, police science and psychology. Authored or co-authored more than 15 training texts, three book length NIC publications early NIC programmed learning course.

PROFESSIONAL ORGANIZATIONS (current and former)

American Correctional Association; American Probation and Parole Association; American Jail Association; California Probation, Parole and Corrections Association; American Psychological Association; International Association of Chiefs of Police

COMMUNITY INVOLVEMENT

Elected Trustee, West Valley-Mission Community College District, three terms. Served as President of Governing Board 1984-85 and 2005-2006. The District serves over 25,000 students, with more than 1000 employees and a budget of over $100 million dollars per year.

Member, Bd. of Directors, former President of large homeowners' association in Saratoga, CA.

Vice Chair, Board of Directors (1988 - 1995), Women's Housing Connection, which was the only homeless shelter in Santa Clara County exclusively for women and women with young children.

Co-founder and Director (1986-2009), Visa Technologies (later Momar Industries), a computer supply and flexible packaging company with over $10M in sales, annually.

Volunteer Mediator, Child Find, Inc., A national organization that attempts to locate missing children, reconcile run-away children and juveniles with their families, and prevent child abduction.

ADDITIONAL SKILLS AND EXPERIENCE

Budget and Personnel Management: As President of a College Board of Trustees, oversaw a budget in excess of $100M/year with approximately 1000 professional and support staff. Oversaw private corporate budget (Visa Technologies) in excess of $10M/year with 65 employees. Extensive experience teaching leadership development, personnel administration, budget and fiscal control and other management topics to criminal justice managers.

Media Relations and Public Speaking: Extensive media experience in community activities as well as with criminal justice work. Frequent public speaking in a wide variety of contexts.

Legislative Liaison and Policy Analysis: Substantial experience working with local legislative delegations, testifying before legislation bodies, analyzing and drafting policy and regulations.

Special Consultant to the California Assembly: (1) Investigation and hearings leading to resignation of Insurance Commissioner Charles Quackenbush. (2) Investigation and hearings on the state of California contract for Oracle software.

APPENDIX B

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LIST OF CASES (May 28, 2019)

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Piszker v. Wackenhut Corrections and Raymond Andrews Case No. 97-16397	Court of Common Pleas Delaware County Civil Trial Division	Defense Sean Halpin @ Reed Smith Shaw & McClay 2500 One Liberty Plaza 1650 Market St. Philadelphia, PA 19103 Office: 215-851-8100	Couple sued private corporation running Delaware County Jail for injuries received from an inmate who had escaped from the jail.	Case settled.	Wrote report.
Mahar v. City of Reed City, et al. Case No. 1:98CV178	U.S. District Court Western District of Michigan, Southern Division	Plaintiffs Diane Goller Dilley, Markowski & Goller, PLLC 1000 Trust Building 40 Pearl Street, NW Grand Rapids, MI 49503 Office: 616-4598383	Resident sued Reed City Police Department for unlawful arrest resulting in injuries. Arrest was made pursuant to a littering citation.	Case settled.	Wrote report, deposed.
Gonzalez v. New Mexico Department of Corrections, et al.	13th Judicial District Court, County of Valencia, New Mexico	Defense Timothy S. Hale Riley, Shane & Hale 4101 Indian School Rd. NE Albuquerque, NM 87110 Office: 505-883-5030	Correctional officer sued State Department of Corrections for injuries resulting from his participation in an emergency preparedness drill.	Ruling for Defense.	Wrote report.
Jeffers v. James Gomez, et al. Case No. CIV S-97-1335	U.S. District Court Eastern District	Plaintiff John Houston Scott The Scott Law Firm 1375 Sutter Suite 222 San Francisco, Ca 94109 Office: 415-561-9600	Inmate shot during disturbance at new Folsom Prison, CA DOC.	Case settled.	Wrote report.
Leitner v. Santa Clara County		Defense Doug Allen	Personnel Board disciplinary action against staff over death of mentally disturbed inmate in County Jail.	Judgment for Defense.	Reviewed records and videotapes, consulted with Defense attorneys, wrote report.

2

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
White v. City of Big Rapids, MI, et al. Case No. 1:94-CV-296	U.S. District Court Western District of Michigan, Southern Division	Plaintiffs Dianne Goller Dilley, Murkwski & Goller, PLLC 1000 Trust Building 40 Pearl St. NW Grand Rapids, MI 49503 Office: 616-459-8383	Plaintiffs sued City of Big Rapids MI, a public safety director and two police officers for unlawful arrest, excessive force and civil rights violations because of a broken arm and other injuries that plaintiff sustained pursuant to a police traffic stop.	Case settled.	Wrote report, deposed.
Sandoval v. Terhune, et al. Case No. C99-20027	U.S. District Court Northern Division	Plaintiffs Lawrence Knapp 215 Dorris Plaza Stockton, CA 95204 Office: 209-946-4440	Inmate shot by CA Department of Corrections officer during an altercation among inmates in recreation yard.	Case settled.	Review of documents.
Ford v. Terhune, et al. Case No. CIVS991234	U.S. District Court Eastern District	Plaintiff John Houston Scott The Scott Law Firm 1375 Sutter Suite 222 San Francisco, CA 94109 Office: 415-561-9600	Gay inmate attacked and killed by cellmate in maximum security mental health unit.	Case settled.	Reviewed documents, wrote report.
Klink v. City of Newman, et al. Case No. F-99-6360	U.S. District Court Eastern District Fresno Division	Plaintiff Jeff Klink 9976 Falcon Meadow Dr. Elk Grove, CA 95624 Office: 916-686-1488	Mentally disturbed individual, on amphetamines, shot and killed by Newman policy officer while threatening officer with a shovel.	Case settled.	Reviewed documents, wrote report.
Perez v. Terhune, et al. Case No. C99-20117	U.S. District Court Eastern District San Jose Division	Plaintiff John Houston Scott The Scott Law Firm 1375 Sutter Suite 222 San Francisco, CA 94109 Office: 415-561-9600	Inmate shot by correctional officer during fight with another inmate on Administrative Segregation exercise yard at Salinas Valley State Prison, CA.	Case settled.	Reviewed documents, wrote report.
Little v. Shelby County. Case No. 96-252-M1A	U.S. Federal District Court Western District	Defense Shelby County (Memphis) Kathleen Spruill Shelby County Attorney's Office Donnie Wilson, Chief County Attorney	1983 conditions of confinement case focusing on inmate on inmate violence in county jail. Consent decree entered 1997, county found in contempt 12/00.	Defendants released from court supervision in 2005.	Hired 03/01 as consultant to assist county in improving jail conditions, meeting terms of consent decree. Testified in court as expert for county. Then served as Court expert.

3

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Torrez v. Terhune Case No. 02AS00716	Superior Court of the State of California IN and for County of Sacramento	Plaintiff Roger Naghash 4400 Mac Arthur Blvd. Suite 900 Newport Beach, CA 92660 Office: 9499955-1000	Shooting death of inmate Torrez during a fight between Hispanic and Asian inmates at High Desert State Prison.	Case settled	Reviewed documents, wrote report.
Mack v. Oakland PD Case No. C-00-4599-CAL	U.S. District Court Northern District of California	Plaintiff Rodney Mack, et al. John Burris, Esq. 1212 Broadway Street, Suite 1200 Oakland, CA 94612 Office: 5510-839-5200	Allegations of police misconduct. Over 100 criminal defendants wrongly sentenced.	Stipulated settlement agreement approved by court.	Review documents, drafted consent decree, wrote report (Referred to as "The Riders" case.
Xavier v. San Francisco Police Department	U.S. District Court Northern District of California	Plaintiff Harriet Ross, Esq. One Sansome Street Suite 2000 San Francisco, CA	Allegations of excessive force while incarcerated in San Francisco jail.	Judgment in favor of defendant.	Wrote report, deposed, testified.
Duran v. State of California Case No. GIC 753709	California Superior Court County of San Diego	Plaintiff John Houston Scott The Scott Law Firm 1375 Sutter Suite 222 San Francisco, CA 94109 Office: 415-561-9600	Inmate stabbed in kitchen of CDC prison.	Case settled.	Reviewed documents.
Karr v. Roseville PD		Plaintiff Jeff Klink 9976 Falcon Meadow Dr. Elk Grove, CA 95624 Office: 916-686-1488	Wrongful death claim for the shooting of mentally disturbed man living in a storage unit.	Case settled.	Reviewed documents, wrote report.
Fernandez v. San Francisco Police Department		Plaintiff Andrew Schwartz Casper, Meadows & Schwartz 2121 N. California Blvd. Ste. 1020 Walnut Creek, Ca 94560 Office: 925-947-1147	Plaintiff was inmate in County jail. Deputy had sexual relationship with Plaintiff in jail.	Judgment for defense.	Reviewed documents, prepared declaration.

4

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Sheppard v. San Francisco Police Department Case No. C 01-3424-PJH	United States District Court Northern District of California	Plaintiff Harriet Ross One Embarcadero Center Ste. 500 San Francisco, CA 94111	Excessive force claim pursuant to arrest.	Judgment for Defense.	Reviewed documents, wrote report.
ILWU v. OPD Crowd Control Case		Plaintiff James Chanin 3050 Shattuck Ave. Berkeley, CA 94705 Office: 510-848-4752	Claim against Oakland PD for shooting people with multiple baton rounds, sting ball grenades, etc. during anti-war demonstration.	$4.5 million dollar settlement to Plaintiff Scott Olsen.	Assisting in preparation of model crowd control policy pursuant to seeking a consent decree.
Agredano v. County of San Bernardino SCVSS 098984	San Bernardino Superior Court	Plaintiff David Martinez, Esq. Robins, Kaplan, Miller & Ciresi, LLP 2049 Century Park E., Ste 3400 Los Angeles, CA 90067 Office: 310-552-0130 Fax: 310-229-5800	Inmate with long mental health and suicidal history hung himself from the top bunk. Inmate's family sued for failure to provide adequate medical care.	Case settled.	Reviewed documents.
Watson v. Livermore PD Case No. C-02-2830-WHA	United States District Court Northern District of California	Defense John L. Burris, Esq./State Bar #69888 Law Offices of John L. Burris 7677 Oakport St. Ste 1120 Oakland, CA 94621 Office: 510-839-5200	Claim of racial profiling by African American couple driving through Livermore.	Case settled.	Wrote curriculum for policy training regarding "minority issues with policy", per settlement agreement.
White v. Brown Case No. CIV F-02-5939 OWW SMS	United States District Court Eastern District of California	Plaintiff Stephen Horvath, Esq. 200 East Del Mar Blvd. Ste 202 Pasadena, Ca 91105	Civil rights case brought by family of inmate who died after a staff use of force against him at Corcoran State Prison in California.	Case settled.	
Adam Burke v. Garfield County Sheriff's Department, et al. Case No. 08-cv-00140	U.S. District Court District of Colorado	Plaintiff Andrea L. Blanscet Irwin & Boesen, PC 501 S. Cherry St. Ste 500 Denver, CO 80246 Office: 303-322-2531	Mr. Burke sued alleging that while he was in the Garfield County Jail, he was subject to excessive force including being shot in the testicles with a pepper ball gun, placed in a restraint chair and injured permanently.		Reviewed documents, wrote report.

5

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Anditon v. Priest & Lamarque Case No. C02-3703 MMC	U.S. District Court Northern District of California	Plaintiff Bill Orrick, Esq. Coblentz, Patch, Duffy & Bass 2049 1 Ferry Bldg, Ste 200 San Francisco, Ca 94111 Office: 415-752-6809 Office: 415-772-5712	Mental health inmate at California's Salinas Valley State Prison sued for excessive force after he was sprayed with OC and then injured by baton strikes from officers.	Case settled.	Reviewed documents, wrote report.
Freeman v. Alameda County Case No. C04-1698 SI	U.S. District Court Northern District of California	Plaintiff Frank S. Moore 1374 Pacific Ave San Francisco, Ca 94109 Office: 415-292-6091	Suit alleged deliberate indifferences and failure to protect after homeless, mental health inmate was beaten to death by his cellmate in the Santa Rita (Alameda Co.) CA, jail.	Case settled.	Reviewed documents and consulted.
Cingle, Guardian for Luethke v. Nebraska Case No. BC295053	District Court of Lancaster County, Nebraska	Defense Assistant Attorney General Stephanie Caldwell 2115 State Capitol Lincoln, NE 68509 Office: 402-471-2862	Inmate was beaten to death in a multiple occupancy cell at Diagnostic and Reception Facility in Nebraska.	Judgment for defense.	Wrote report, deposed; testified at trial.
Gavira v. LA County Sheriff Case No. BC2955053	LASC – Central District	Defense Timothy J. Kral Manning & Marder, Kass, Ellrod, Ramirez, LA California Office: 213-624-6900 Fax: 213-624-6999	Family members sued for negligence, deliberate indifference in the failure to provide medical/mental health treatment and for excessive force in the suicide by hanging of a jail inmate.	Settled.	Reviewed documents.
Porras & Grigsby, et al. v. Los Angeles County Case No. CV04-1229 ABC	USDC CV04-1229 RGK (RNBX)	Defense Timothy J. Kral Manning & Marder, Kass, Ellrod, Ramires 801 S. Figueroa Ste. 15 Los Angeles, Ca 90017 Office: 213-624-6900 Fax: 213-624-6999	1983 class action suit; deliberate indifference providing medical services; general failure to provide inmates access to adequate medical services and 14th and 18th amendment violations regarding health care, sanitation and access to council.	Settled.	Reviewed documents.
Ferrel v. City of Santa Rosa Case No. SCV 237557	Superior Court of the State of California	Plaintiff Eric G. Young 141 Stony Circle Ste. 202 Santa Rosa, Ca 95401 Office: 707-575-5005	Plaintiff alleges excessive and unnecessary force by Santa Rosa Police Department.	Case settled.	Reviewed documents, deposed.

6

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Baker v. State of Nebraska Docket No. 1044 545	District Court of Douglas County, Nebraska	Defense Ms. Maureen Hannon, Ms. Stephanie A. Caldwell, Assistant Attorneys General 2115 State Capitol Lincoln, NE 68509	Couple sued state for negligence after inmate escaped and invaded their home, injured them.	Case settled in 2008.	Wrote report.
Harris v. Grams, et al. Case No. 07-CV-678	United States District Court for the Western District of Wisconsin	Plaintiff Pamela McGillivray and Carlos Pabellon Garvey, McNeil & McGillivray, S.C. 634 W. Main St. Ste 101 Madison, WI 53703 Office: 608-256-1003	Inmate sued for deliberate indifference in denying medical treatment and for retaliation.	Settled.	Reviewed documents, wrote report, deposed.
Trina S. Garcia v. Zavares, et al. Case No. 1:08-CV-02780	U.S. District Court, District of Colorado	Plaintiff Andrea L. Blanscet Irwin & Boesen 501 S. Cherry St. Ste 500 Denver, CO 80246 Office: 303-322-2531	Ms. Garcia was an inmate in the CO DOC who was coerced into sex by a male staff member who was supervising her and was also having sex with at least three other female inmates.		Reviewed documents, wrote report.
David Ramirez v. County of Los Angeles, et al. Case No. CV-08-2813	U.S. District Court Central District of California, Western Division	Plaintiff Navid Sulimani & Adam J. Rottenberg Proskauer Rose, LLP 2049 Century Park East Ste. 3200 Los Angeles, CA 90067 Office: 310 284-4541	Mr. Ramirez was an inmate at Men's Central Jail and sued for injuries as a result of "serial extraction" of segregation unit.	Verdict for Defense.	Reviewed documents; wrote report; deposed; testified at trial.
Troy Short v. AJ Trujillo, et al. Case No. 08-CV-02209	U.S. District Court, District of Colorado	Plaintiff Jared B. Briant & Spencer B. Ross Faegre & Benson, LLP 1700 Lincoln St. Ste 3200 Denver, CO 80203 Office: 303-607-3500	Mr. Short was an inmate in the CO DOC and was harassed, threatened and beaten by gang related inmates. He sued for failure to protect him.	Case settled.	Reviewed documents, wrote report, deposed.
Shannon Bastedenbeck v. Zavaras, et al. Case No. 08-CV001841	U.S. District Court District of Colorado	Plaintiff Andrea L. Blanscet Irwin & Boesen 501 S. Cherry St. Ste 500 Denver, CO 80246 Office: 303-322-2531	Ms. Bastedenbeck was an inmate in the CO DOC and was coerced into sexual relation by a Lieutenant. She sued Department Administrators and Supervisors for damages.		Reviewed documents, wrote report.

7

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Oscar Garay, Jr., by Kelly Sue Garay v. Hamblen County Tennessee Case No. 2:11-CV-00128	U.S. District Court Eastern District of Tennessee	Plaintiff Robert Bates Law Offices of Tony Seaton 118 E. Watauga Ave. Johnson City, TN 37601 Office: 423-282-1041	Mr. Garay died as a result of a seizure while in a restraint chair in the Hamblen County Jail. His estate sued for failure to provide medication, medical treatment and for other causes.	Case settled.	Reviewed documents, wrote initial and supplemental report, deposed.
Jeffrey Marshall v. Deputy Castro, et al. Case No. S:04-1657	U.S. District Court Eastern District of California	Plaintiff Scotia J. Hicks, Yelitza V. Dunham & Craig Crockett Winston & Strawn, LLP 101 California St. San Francisco, CA 94111 Office: 415-591-1000	Mr. Marshall sued for unnecessary and excessive force on the part of Deputies in the Solano County, Ca Jail.	Case settled.	Reviewed documents, wrote initial and supplemental report, deposed.
Laura Lobozzo v. Colorado Department of Corrections, et al. Case No. 08-CV-01829	U.S. District Court Western District of Michigan, Southern Division	Plaintiff Andrea L. Blanscet Irwin & Boesen 501 S. Cherry St. Ste 500 Denver, CO 80246 Office: 303-322-2531	Laura Lobozzo was threatened and coerced into a sexual relationship by a male correctional officer while she was an inmate in the CO DOC. She sued for damages.		Reviewed documents, wrote report.
Estate of John Ketchapaw v. County of Ottawa, et al. Case No. 1:10-cv-320	U.S. District Court Western District of Michigan, Southern Division	Plaintiff Neal J. Wilensky Kaechele & Wilensky, PC 6500 Centurion, Ste 230 Lansing, MI 48917 Office: 517-853-1940	John Ketchapaw committed suicide. Plaintiff sued for damages based on Defendants alleged failure to appropriately screen Mr. Ketchapaw for suicide risk and to take appropriate preventative actions.	Case settled.	Reviewed documents, wrote report.
Don Antoine v. County of Sacramento Case No. 2:06-CV-01349	U.S. District Court Eastern District of California	Plaintiff John Houston Scott The Scott Law Firm 1375 Sutter St. Ste 222 San Francisco, CA 94109 Office: 415-561-9600	Mr. Antoine sued for damages alleging that several deputies had entered his cell, used excessive force, seriously injured him and then chained his handcuffs and leg shackles to the toilet drain grate in the cell floor and left him.	On appeal.	Wrote report; deposed; testified at trial.

8

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Anthony Ferrel, et al. v. City of Santa Rosa, et al. Case No. SCV-237557	Superior Court State of California County of Sonoma	Plaintiff	Plaintiff and family members sued alleging that City of Santa Rosa police officers used excessive force in tasering, beating and pointing firearms at Mr. Ferrel and family members.	Case settled.	Reviewed documents, wrote report, deposed.
Krenn v. County of Santa Clara, et al. Case No. C07-2295	U.S. District Court Northern District of California	Defense David Sheuerman of Sheuerman, Martini & Tabari, PC 1033 Willow St. San Jose, CA 95125 Office: 408-288-9700	Andrew Martinez, a frequent mental health inmate in the Santa Clara County Jail, committed suicide in the jail in May 2006. His mother subsequently sued for failure to prevent the suicide.	Case settled.	Reviewed documents, wrote report.
Snyder & Santoro v. City and County of San Francisco Case No. 03-04927	U.S. District Court Northern District of California	Plaintiff John Houston Scott The Scott Law Firm 1375 Sutter St. Ste 222 San Francisco, CA 94109 Office: 415-561-9600	Mr. Snyder and Mr. Santoro alleged that they were walking out of a restaurant when two off duty SF police officers savagely beat them because they were gay. (Case referred to in SF as "Fajita – gate".)	Case settled.	Provided declaration on police Early Warning Systems, Progressive Discipline Systems, Effective Police Supervision, etc.
Daniel Duran v. State of California, et al. Case No. GIC753709	State of California San Diego Superior Court	Plaintiff Suzie Moore Law Offices of Suzie Moore 1901 First Ave. Ste 227 San Diego, CA 92101 Office: 619-231-9490	Mr. Duran sued after he was attacked and stabbed repeatedly by several other inmates at Centinela State Prison.	Case settled.	Reviewed documents, wrote report, deposed.
Lynette Frary (Carmignani) v. County of Marin (City of Novato) Case No. C-12-3928-MEJ	United States District Court Northern District of California	Plaintiff David L. Fiol, Attorney at Law Brent, Fiol, & Nolan LLP Two Embarcadero Center, 18th Floor San Francisco, CA 94111	Inmate died in custody from opiate overdose resulting from ingesting morphine pills prior to booking.	Settled	Received documents
Lawrence Carty v. John Dejongh (US Virgin Islands) Case No. 94-78	District Court of the Virgin Islands Division of St. Thomas and St. John	Appointed by Federal Court as the Court's Security Expert. The Honorable Judge Stanley S. Brotman.	Long-standing consent decree over conditions of confinement at two jails on St. Thomas, USVI.	Consent Decree ongoing	Conducted security audit, wrote report, testified on two occasions at Federal Court hearings in USVI.

9

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
LaShawn Jones, et al., v. Marlins Gusman, Sheriff, Orleans Parish, et al. Case No. 2:12-cv-00859	United States District Court Eastern District of Louisiana	Plaintiff Katie Schwartzman Director, Louisiana Office Southern Poverty Law Center 1055 St. Charles Ave., Suite 505 New Orleans, LA 70130	Class action suit over conditions of confinement in the New Orleans jails, jointly litigated by Southern Poverty Law Center and Special Litigation Section of Civil Rights Division of US DOJ.	Consent decree entered.	Conducted security audit of New Orleans jail facilities, wrote report, testified at hearing over consent decree.
Nathaniel L. Jackson v. Perry Phelps Case No. 10-919-SLR	United States District Court District of Delaware	Plaintiff Erika Caesar Young Conawa Stargatt & Taylor, LLP Rodney Square 1000 North King Street Wilmington, DE 19801	Inmate alleges cruel and unusual punishment for being placed in full restraints, left in cell for 24 hours in underpants as punishment for flooding cell.	Settled	Wrote report, deposed.
Ronald E. Johnson v. Douglas Weber Case No. CIV-12-4084	United States District Court District of South Dakota Southern Division	Plaintiff John Burke Thomas Braun Bernard & Burke, LLP 4200 Beach Drive Suite 1 Rapid City, SD 57702	Civil Rights suit by wife of Correctional Officer who was beaten to death in an escape attempt by two inmates at South Dakota state prison.	Dismissed pursuant to Defense motion.	Wrote report, deposed.
Aleshia Cyrese Henderson v. Stanley Glanz, Sheriff Case No. 12-cv-68-TCK-FHm	United States District Court Northern District of Oklahoma	Defense Guy Fortney, Esq. Corbin Brewster, Esq. Law Offices of Brewster & DeAngelis, P.L.L.C. 2617 East 21st Street Tulsa, OK 74114	Female inmate sues Sheriff for damages after she alleged rape by male inmate in medical area of jail.	Settled	Wrote report, deposed.
LaDona Poore v. Stanley Glanz, Sheriff Case No. 11-cv-797-CVE-TLW	United States District Court Northern District of Oklahoma	Defense Guy Fortney, Esq. Corbin Brewster, Esq. Law Offices of Brewster & DeAngelis, P.L.L.C. 2617 East 21st Street Tulsa, OK 74114	Former adolescent female inmate sues Sheriff alleging rape and other sexual assaults by male correctional officer.	$25,000 verdict for Plaintiff. On appeal.	Wrote report, deposed.
Linsey Dawn Shaver v. Stanley Glanz, Sheriff Case No. 12-Cv-234-CVE-PJC	United States District Court Northern District of Oklahoma	Defense Guy Fortney, Esq. Corbin Brewster, Esq. Law Offices of Brewster & DeAngelis, P.L.L.C. 2617 East 21st Street Tulsa, OK 74114	Female adolescent inmate sues Sheriff alleging sexual misconduct by male correctional officer in medical area of jail.	Pending	Wrote report.
Jeffrey Trevillion v. Stanley Glanz, Sheriff Case No. 12-CV-146-JHP-TLW	United States District Court Northern District of Oklahoma	Defense Guy Fortney, Esq. Corbin Brewster, Esq. Law Offices of Brewster & DeAngelis, P.L.L.C. 2617 East 21st Street Tulsa, OK 74114	Male inmate sues Sheriff over failure to provide wheel chair, excessive use of force and failure to provide medications.	Settled	Reviewed documents

10

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
CRIPA Investigation of Violence Issues Effecting Male Adolescent Inmates on Rikers Island Case No. 11-Cv-5845	United States District Court Southern District of New York	Plaintiff Emily A. Daughtry Jeffrey K. Powell Assistant United States Attorneys US Department of Justice Southern District of New York 86 Chambers St. New York, NY 10007	CRIPA investigation of staff use of force and inmate-on-inmate violence involving male adolescent inmates on Rikers Island.	Formal agreement reached under Federal Court Supervision	Reported to US Attorney's Office following assessment of condition for juveniles on Rikers. Participated in drafting/negotiating consent decree.
Marvin Hunter v. Jerome Wilen, Case No.	United States District Court Western District of Washington at Tacoma	Plaintiff Fred Diamondstone 1218 Third Ave., Suite 1000 Seattle, WA 98101	Inmate in Washington DOC has filed suits in State and Federal Court alleging he was assaulted by prison gang because Department wrongfully published information that he was a confidential informant then refused him protective custody or transfer.	Settled	Wrote report, deposed.
Michael Miceli v. Marlin Gusman, Sheriff Case No. 09-8078	United States District Court Eastern District of Louisiana	Plaintiff Mary E. Howell 316 S. Dorgenois St. New Orleans, LA 70119	Suicidal female inmate died in custody as a result of being placed in 5-point restraints on her back for 4 hours and staff using force to hold her down.	Settled	Received documents
Margaret Goetzee Nagle and John Eric Goetzee v. Marlin Gusman, Sheriff Case No. 12-1910	United States District Court Eastern District of Louisiana	Plaintiff Mary E. Howell 316 S. Dorgenois St. New Orleans, LA 70119	Widow of Coast Guard Commander sues Sheriff, Sheriff's employees, after her husband commits suicide on the tenth floor, mental health unit of the House of Detention.	Settled	Wrote report, deposed.
Jesse Goode v. County of Genesee Case No. 12-10340	United States District Court Eastern District of Michigan Southern Division	Plaintiff Neal Wilensky 6005 W. St. Joseph, Suite 303 Lansing, Michigan 48917	Inmate died as a result of opiate overdose ingested while in custody in the Genesee County Jail.	Settled	Wrote report, deposed.
Thomas Gould v. Board of County Commissioners of Major County Case No. CIV-11-290-M	United States District Court Western District of Oklahoma	Plaintiff Michael E. Grant Musser, Kouri, Bentwood & Grant 114 E. Sheridan, Suite 102 Oklahoma City, OK 73104	Wife arrested for possession when went to visit her husband in jail. Wife subsequently committed suicide by hanging in jail.	Dismissed pursuant to Defense motion.	Wrote report, deposed.

11.

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Phillip Morris, Jr. v. R. A. White, et al. Case No. CV-08-02823-DOC (SSx)	United States District Court Central District of California	Plaintiff Katherine A. Rykken Latham & Watkins, LLP 355 South Grand Ave Los Angeles, CA 90071	Inmate in California Department of Corrections sued alleging excessive force by staff after inmate ran from two officers and across exercise yard.	Settled	Wrote report.
Cook County Case No. 13 CV 8752	United States District Court Northern District of Illinois	Plaintiff Sheila Bedi, Esq. David Shapiro, Esq.' McCarther Justice Center, Northwestern University Law School	A class action suit against the Cook County Jails focusing on staff use of force and inmate-on-inmate violence.	Case dismissed on motion by circuit court.	Wrote report; deposed testified at hearing.
Pickens v Management Training Corp	In The United States District Court For the Southern District of Mississippi Northern Division	Plaintiff Yancy B. Burns Burns & Associates, PLLC P.O. Box 16409 Jackson, MS 39236	Inmate lost one eye after stabbed and beaten in riot/gang war at private prison in MS.	Settled	Wrote report
Rosales v State of Nebraska Case No. CI 13-717	District Court of Lancaster County, Nebraska	Defense Bijan Koohmaraie Assistant Attorney General Nebraska Department of Justice 2115 State Capitol Lincoln, Nebraska 68509	Plaintiff suffered brain damage as result of assault by another inmate. Plaintiff sued state for failure to protect.	Verdict for Defense	Testified at trial.
Christopher Shapard v. John Attea, et al. Case No. 08-CV-6146 (CJS)	United States District Court Western District of New York	Plaintiff Luke X. Flynn-Fitzsimmons Paul, Weiss, Rifkind, Wharton & Garrison, LLP 1285 Avenue of the Americas New York, NY 10019	Plaintiff was inmate at Wende Correctional Facility in N.Y. DOC. Plaintiff alleges that three correctional officers beat him as retaliation.	Verdict for Defense	Wrote report; deposed.
Anthony Josta v. Woodbury County Case No. 13-97-0060	In The United States Disctrist Court Northern District of Iowa Western Division	Plaintiff John f. Carroll, RN, JD Attorney 2809 S. 160th Street, Suite 409 Omaha, NE 68130	Plaintiff died due to alcohol withdrawal while he was in the Woodbury County, Iowa, Jail.	Settled	Wrote report.
Anita Arrington-Bey, Administration of the Estate of Omar K. Arrington-Bey v. City of Bedford Heights, et al. Case No. 1:14-CV-02514	Court of Common Pleas Cuyahoga County, Ohio	Plaintiff Jacqueline Green Friedman & Gilbert 55 Public Square, Suite 1055 Cleveland, OH 44113	Plaintiff died in custody in the Bedford Heights, Ohio, jail following his placement in a restraint chair after he assaulted two officers in the jail.	Settled	Wrote report, deposed.
Case Name & Number	**Court**	**Retained By**	**Summary of Case**	**Disposition**	**Participation**

12

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Kelly Conrad Green v. Corizon Health, Inc. Case No. 42 USC 1983	United States District Court for the District of Oregon Eugene Division	Plaintiff Elden M. Rosenthal 121 S.W. Salmon St, Suite 1090 Portland, OR 97204	Plaintiff sued for failure to protect and failure to provide adequate medical services after he sustained permanent injuries.	Settled	Reviewed documents.
Farris v. Island County Case No. 15-105352	Case settled before filing	Plaintiff Rebecca J. Roe Schroeter Goldmark Bender 810 Third Avenue, Suite 500 Seattle, WA 98104	Inmate died of dehydration and malnutrition while in custody for 11days in the Island County, WA Jail.	Settled	Reviewed documents.
Meirs v. Ottawa County Case No. 1:15-cv-00866	United States District Court Western District of Michigan	Plaintiff Steven T. Budaj Goodman & Hurwitz, PC. 1394 E. Jefferson Ave. Detroit, MI 48207	Inmate committed suicide while in custody in Ottawa County, MI, jail.	Verdict for defense	Wrote report; deposed; testified at trial.
Brian Otero v. Thomas J. Dart, Sheriff of Cook County Case No. 1:12-dv-03148	United States District Court for the Northern District of Illinois – Eastern Division	Plaintiff Jacie Zolna, Esq. Myron M. Cherry & Associates, LLC 30 North La Salle St., Suite 2300 Chicago, Illinois 60602	Class action suit alleging male prisoners in Cook County Jail held unnecessarily, endangered and treated differently than female prisoners after "not guilty" verdict.	Settled	Wrote report; deposed.
Glover v. Jayson Vest, et al Case No. CIV-14-936-F	In the United States District Court for the Western District of Oklahoma	Plaintiff Rachel S. Fields Atkinson, Haskins, Nellis, Brittingham, Gladd & Fiasco, P.C. 525 South Main Tulsa, OK 74103	Staff sexual misconduct. Rape of female inmate in Harmon Co., OK jail by Deputy Chief of Police of Hollis, OK Police Department.	Jury award of 6.5 million dollars to Plaintiff	
Wilmer Catalan-Ramirez v. Ricardo Wong, Field Office Director, Chicago, U.S. Immigration and Customs Enforcement, et al.	District Court for the Northern District of Illinois Easter Division	Plaintiff Sheila Bedi, Esq. David Shapiro, Esq.' McCarther Justice Center, Northwestern University Law School	Handicapped Plaintiff was being transported in restraints without a seatbelt.		Testified by phone at Preliminary hearing
Donnie Ray Brown, et al. v. Conmed Healthcare Management, Inc., et al. Case No. 6:14-cv-01620-TC	United States District Court District of Oregon Eugene Division	Plaintiffs Benjamin W. Haile Attorney at Law P.O. Box 2581 Portland, OR 97208	Failure to provide medical treatment. Inmate in Coos Bay County, OR, jail died after failure to treat him for a perforated ulcer and peritonitis.	Settled	Wrote report and supplemental report.
Matthew Allen v. State of Oregon, et al., Case No. 3:11-CV-0218-PK	United States District Court District Court of Oregon Portland Division	Plaintiffs Benjamin W. Haile Attorney at Law P.O. Box 2581 Portland, OR 97208	Failure to protect (inmate-on-inmate gangs). Inmate in OR State Prison beaten by former gang after requesting protection.	Settled after state stipulated to liability on all three counts.	Reviewed documents.

13

Chris Blevins, et al. v. Marlin N. Gusman and Orleans Parish Sheriff's Office Case No. 2013-04979	Civil District for the Parish of Orleans State of Louisiana	Plaintiff Suzette Bagneris The Bagneris Firm, LLC 4919 Canal Street, Suite 104 New Orleans, Louisiana 70119	Failure to protect (inmate-on-inmate gangs). Male inmate stabbed to death in New Orleans Parish jails.	Settled	Reviewed documents.
Hamilton v. Correctional Health Care Management, Inc, et.al. Case No. CIV-09-544-M	In the United States District Court for the Western District of Oklahoma	Plaintiff Venessa Brentwood Durbin, Larimore & Bialick 920 N. Harvey Oklahoma City, OK 73102	Failure to provide medical treatment. Inmate died after staff use of force, lengthy time in restraint chair at the Oklahoma County Detention Center	Settled.	Wrote report; deposed.
The Estate of Joice Howard v. County of Genesee, et al. Case No. 14-12350	**Cannot find Complaint**	Plaintiff Neal Wilensky 6005 W. St. Joseph, Suite 303 Lansing, Michigan 48917	Failure to provide medical treatment. Female inmate in Genessee Co., MI, jail had high blood pressure and gran malsciziures. Got no medication and died.	Settled	Wrote report.
Katka v. State of Montana, el. al. Case No. BDV-2009-1163	Moutana First Judicial District Court Lewis and Clark County	Plaintiff Andree Larose Morrison, Motl & Sherwood, PLLP 401 N. Last Chance Gulch Helena, MT 59601	Juvenile held in high security at Montana State Prison. Conditions of confinement, failure to provide treatment.	Settled	Wrote report.
James Joshua Mayfield, et al. v. Orozco et al. Case No. 2:13-CV-02499-JAM-AC	United States District Court Eastern District of California, Sacramento Division	Plaintiff Josh Piovia-Scott Hadsell Stormer Renick, LLP 128 North Fair Oaks Avenue Pasadena, CA 91103	Failure to protect (suicide attempt).	Settled.	Wrote report.
James Merchant v. Woodbury County, et al. Case No. 7C16-CV-4111		Plaintiff John F. Carroll Watson & Carroll PC LLO 2809 S. 160th Street, Suite 409 Omaha, NE 68130-1755	Failure to provide medical treatment at the Woodbury Co., IA, jail. Inmate's stroke-like symptoms disregarded, inmate suffered permanent and profound impairment.	Settled	Wrote report.
Glenda Millington v. Corrections Corporation of American, et.al. Case No. 10-CIV-650-L	The United States District Court for the Western District of Oklahoma	Plaintiff Steven J. Terrill Bryan & Terrill Law, PLLC 401 S. Boston, Suite 2201 Tulsa, OK 74103	Failure to protect inmate-on-inmate gangs. Inmate at Cinnarron, private prison in Oklahoma, badly beaten in gang incident. Permanent, serious brain damage.	Settled	Wrote report and declaration; deposed.
Case Name & Number	**Court**	**Retained By**	**Summary of Case**	**Disposition**	**Participation**
Williams v. Williams, et al.	In the United States District Court for the Central District	Plaintiff Leila Azari Latham & Watkins,	Inmate in L.A. Co. jails, at IRC, was in wheel chair and alleged	Settled.	Wrote report; deposed; retained as rebuttal witness.

14

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Case No. CV08-7958-JVS	of California	LLP 355 South Grand Ave Los Angeles, CA 90071	unnecessary staff use of force		
People of the State of New York v. Anthony Criscuolo Case No. 2055-2013	Supreme Court of the State of New York County of Bronx	Plaintiff Steven A. Metcalf II, Esq. The Metcalf Law Firm, PLLC 11 Broadway, Suite 615 New York, New York 10004	Motion to set aside. Guilty plea as a result of pre-trial conditions.		Took case pro bono; provided declaration.
Jon Watson v. Cumberland County, et al. Case No. 1:16-cv-06578-JHR-AMD	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Law Offices of Conrad Benedetto *Conrad Benedetto* 323 East Front Street Media, Pa. 19063	Suicide in the Cumberland County New Jersey Jail	Pending	Wrote report; deposed.
David Hennis v. Cumberland County, et al. Case No. 1:16-cv-04216	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Law Offices of Conrad Benedetto *Conrad Benedetto* 323 East Front Street Media, Pa. 19063	Suicide in the Cumberland County New Jersey Jail	Pending	Wrote report
Alissa Allen v. Cumberland County, et al. Case No. 1:15-CV-06273-JBS-AMD	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Law Offices of Conrad Benedetto *Conrad Benedetto* 323 East Front Street Media, Pa. 19063	Suicide in the Cumberland County New Jersey Jail	Pending	Wrote report.
Estate of Megan Moore, et al, v. Cumberland County Case No. 17-cv-2839-RBK-KMW	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Law Offices of Conrad Benedetto *Conrad Benedetto* 323 East Front Street Media, Pa. 19063	Suicide in the Cumberland County New Jersey Jail	Pending	Reviewed documents.
Estate of David Conroy et al, v. Cumberland County Case No. 1:17-cv-07183-RBK-AMD	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Law Offices of Conrad Benedetto *Conrad Benedetto* 323 East Front Street Media, Pa. 19063	Suicide in the Cumberland County New Jersey Jail	Pending	Reviewed documents.
(Johnson, Lamar) Adrienne Lewis, by and on behalf of the minor child Liya Alexandria Johnson v. East Baton Rouge Parish, et al. Case No. 16-352-JWD-RLB	United States District Court Middle District of Louisiana	Plaintiff The Claiborne Firm, P.C. David J. Utter, Esq. 410 E. Bay Street Savannah, GA 31401	Suicide in the East Baton Rouge Parish Jail	Settled	Wrote report.

15

Jonathan Fano v. East Baton Rouge Parish, et al. Case No. 3:17-cv-00656-SDD-EWD	United States District Court Middle District of Louisiana	Plaintiff The Claiborne Firm, P.C. David J. Utter, Esq. 410 E. Bay Street Savannah, GA 31401	Suicide in the East Baton Rouge Parish Jail by mentally ill male inmate.	Pending	Reviewed documents.
Frazier, Tayo Case No. 16-cv-2364	United States District Court for the Central District of Illinois Urbana Division	Plaintiff Shayla Maatuka Dodd & Maatuka 303 S. Mattis Ave, Suite 201 Champaign, IL 61821	Failure to provide medical services to female inmate going through withdrawal in Champaign Co. Jail. Inmate died.	Pending	Wrote report; deposed.
Cordell Johnson v. Correctional Corporation of America, et al. Case No. CIV-16-1061-R	In the United States District Court for the Western District of Oklahoma	Plaintiff Bryan & Terrill Spencer Bryan Steven Terrill 9 East Fourth Street, Suite 307 Tulsa, Oklahoma 74103	Failure to protect Inmate-on-inmate gang fight/riot in Cimmaron CCA operated private prison in OK. Inmate stabbed and permanent injuries.	Settled	Wrote report
Steve Tiffee, as Special Administrator for the Estate of Kyle Tiffee v. Corrections Corporation of America, et al. Case No. CJ-2016-378	In the District Court for Payne County State of Oklahoma	Plaintiff Bryan & Terrill Spencer Bryan Steven Terrill 9 East Fourth Street, Suite 307 Tulsa, Oklahoma 74103	Failure to protect. Inmate stabbed seriously injured in riot/gang war at Cimarron CCA operated prison in OK.	Pending	Reviewed documents.
Tyson Christian v. Willamette Community Health Solutions Case No. 6:17-cv-00885-AA	United States District Court For the District of Oregon Eugene Division	Plaintiff Patrick D. Angel Angel Law PC 6960 SW Varns Street, Suite 110 Portland, OR 97223 John T. Devlin Devlin Law, P.C. 1212 SE Spokane Street Portland, OR 97202	Failure to protect alcoholic inmate found unresponsive on floor of jail cell; died.	Settled	Reviewed documents.
Jacob Parenti v. County of Monterey; Sheriff Scott Miller Case No. 5:14-cv-05481	United States District Court Northern District of California	Plaintiff Joshua Piovia-Scott, Esq. Hadsell Stormer & Renick, LLP 128 North Fair Oaks Avenue Pasadena, CA 91103	Failure to provide medical care, negligence and wrongful death	Settled	Wrote report; deposed.
Estate of Laura Semprevivo, et al, v. Cumberland County Case No. 17-cv-2839-RBK-KMW	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Conrad Benedetto Attorney at Law Law Offices of Conrad J. Benedetto 1615 S. Broad Street Philadelphia, PA 19148	Suicide in the Cumberland County, New Jersey Jail	Pending	
Case Name & Number	**Court**	**Retained By**	**Summary of Case**	**Disposition**	**Participation**

16

Madaline Pitkin v. Corizon Health, Inc. Case No. 3:16-cv-02235-AA	United States District Court District of Oregon – Portland Division	Plaintiff John Coletti Paulson Coletti 1022 NW Marshal, Ste. 450 Portland, OR 97209	Failure to provide appropriate medical care to young female inmate undergoing withdrawal in the Washington County Oregon Jail	Settled for 10 million dollars.	Wrote reports.
Rocky Stewart v. Coos County Jail	Complaint not yet filed.	John T. Devlin Devlin Law, P.C. 1212 SE Spokane Street Portland, OR 97202	Failure to provide appropriate medical care		Reviewed documents
Abdiwali Musse v. William Hayes, et al. Case No. C18-1736-JCC	United States District Court Western District of Washington at Seattle	Plaintiff Jay Krulewitch 2611 N.E. 113th Street, Suite 300 Seattle, WA 98125	Inmate in King Co. Jail attacked and seriously injured while he slept in congregate cell.	Pending	
Markist Webb v. Management & Training Corporation Case No. 15-CV-029-LE-C	In the Circuit Court of Leake County, Mississippi	Plaintiff S. Todd Jeffreys, Esq. Povall & Jeffreys, P.A. P.O. Box 1199 215 North Pearman Ave. Cleveland, MS 38732	Inmate seriously injured in riot/gang war at privately run prison (Walnut Grove) in MS.	Settled	Reviewed documents.
Christopher Thomas Woolverton v. Barry Martin, et al. Case No. 2:15-cv-00314-J	United States District Court for the Northern District of Texas Amarillo Division	Plaintiff Ben Haile Attorney at Law P.O. Box 2581 Portland, OR 97208	Fatal abuse of seriously mentally ill inmate who also suffered from medical significant problems, in a Texas State Prison.	Pending	Wrote report; provided declaration.
Anthony Huff v. Garfield County Sheriff's Office		David Donchin, Esq. Durbin, Larimod & Bialick, PC Oklahoma City, Oklahoma			
Robert W. Lewis v. Cumberland County, et al. Case No. 1:16-cv-03503	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Law Offices of Conrad Benedetto *Conrad Benedetto* 323 East Front Street Media, Pa. 19063	Suicide in the Cumberland County New Jersey Jail	Pending	Wrote report; deposed.

APPENDIX C

Jeffrey A. Schwartz, Ph.D.
1610 La Pradera Drive
Campbell, California 95008
(408) 379-9400 ♦ FAX (408) 379-9410
jasletra@aol.com

Expert Witness Fee Schedule (9/10/18)

1. Document review and other case preparation: $325 per hour

2. Testimony at deposition or trial: $425 per hour (Minimum charge $1,700 or 4 hours)

3. Airfare, car rental, meals and incidentals on travel status, and other case expenses: Cost reimbursable

4. Retainer: Agreed to on case by case basis, typically $2,500

5. Initial case review, typically up to 4 hours: No charge if not retained or if case declined. Charged at case preparation rate if retained and case accepted.

APPENDIX D

Recent Publications
Jeffrey A. Schwartz

1. A note on "Verbal and Non-verbal Indicators to Assault"; Corrections.com; May, 2009.
2. "Planning for the Last Disaster; Correctional Facilities and Emergency Preparedness; Journal of Emergency Management; Volume 7, #1; January/February, 2009.
3. Reducing Exposure in Use of Force Litigation; Corrections Today; June, 2009.
4. "The Force Continuum: Is It Worth Keeping? Part 1; Bill Collins, Jeffrey A. Schwartz and Donald Leach; Correctional Law Reporter; December/January, 2011.
5. "The Force Continuum: Is It Worth Keeping? Part II"; Bill Collins, Jeffrey A. Schwartz and Donald Leach; Correctional Law Reporter; April/May, 2011.
6. "Come and Get Me! The Best and Worst in Cell Extractions"; American Jails; July/August, 2009.
7. Turn Around in a Good Jail; Gary Raney and Jeffrey A. Schwartz; American Jails; January/February, 2008.
8. "Fixing Use of Force Problems"; American Jails, January/February, 2010.
9. "A Guide to Preparing for and Responding to Jail Emergencies"; Jeffrey A. Schwartz, Ph.D. and Cynthia Barry, Ph.D.; a book-length monograph published by the National Institute of Corrections; 2009.
10. "A Guide to Preparing for and Responding to Prison Emergencies;" Jeffrey A. Schwartz, Ph.D. and Cynthia Barry, Ph.D.; June, 2005; a book length monograph published by the National Institute of Corrections.

APPENDIX E

List of Documents for East Baton Rouge Parish Prison Litigation Jonathan Fano

1. Retainer agreement for Jeffrey A. Schwartz from The Claiborne Firm, P.C. re: East Baton Rouge Parish Prison Litigation dated November 14, 2017. 3 pgs.
2. Complaint Case No. 3:17-cv-00656-SDD-EWD dated September 20, 2017. 38 pgs.
3. Health Management Associates Report and Recommendations Clinical Operations at East Baton Rouge Parish Prison. 28 pgs.
4. Standards for Mental Health Services in Correctional Facilities. 17 pgs.
5. Some Positive Features/Aspects of Care at EBR Prison Draft 3/6/16. 10 pgs.
6. East Baton Rouge Prison. 14 pgs.
7. Deposition of Robert Blanche, M.D. Civil Docket No. 3:17-CV-00656-JWD-EWD & Civil Docket No. 3:16-cv-352-JWD-RLB dated June 11, 2019 and Exhibits.
8. Deposition of Lisa Burns and Exhibits 1-7 Civil Docket No. 3:17-CV-00656-JWD-EWD dated October 3, 2019.
9. Exhibit 7: Policies and Procedures Sub: Disciplinary Procedures revised 01/04/16. 10 pgs.
10. Deposition of Warden Dennis Grimes Civil Docket No. 3:17-CV-00656-JWD-EWD dated July 22, 2019 and Exhibits.
11. East Baton Rouge Parish Prison Disciplinary Report of Louis Fano dated November 1, 2016. 2 pgs.
12. Exhibit 3: Lockdown Review from Lt. Bryan Simmons dated January 3, 2017. 6 pgs.
13. Deposition of Danielle Thomas Civil Docket No. 3:17-CV-00656-JWD-EWD dated June 19, 2019 and Exhibits.
14. U.S. Department of Justice Report and Recommendations Concerning the Use of Restrictive Housing Final Report dated January 2016. 7 pgs.
15. M & N Control Log Started October 10, 2016 & Ended November 19, 2016. 79 pgs.
16. N-Wing Control Log Started October 31, 2016 & Ended December 17, 2016. 153 pgs.
17. Men Control Log Started November 19, 2016 & Ended December 28, 2016. 161 pgs.
18. N-Wing Control Log Started January 9, 2017 & Ended February 2, 2017. 49 pgs.
19. M & N Control Log Started January 9, 2017 & Ended February 2, 2017. 53 pgs.
20. Clinical Services Operations Policies and Procedures. 75 pgs.
21. M & N Control Logbook dated December 28, 2016. 27 pgs.
22. N-Wing Control Logbook Started date December 17, 2016 & Ended January 9, 2017. 41 pgs.
23. 34 Videos
24. Staff Activity Report – Blanche, Robert CHEBR03295-CHEBR03322 28pgs.
25. Staff Activity Report – Burns, Lisa CHEBR03323-CHEBR03329 6pgs.
26. Deposition of Jean Llovet Civil Docket No. 3:17-CV-00656-JWD-EWD Dated September 19, 2019 and Exhibits.
27. Sworn Statement of Daniel Hinton, JR. Civil Docket No. 3:17-CV-00656-JWD-EWD 4pgs
28. Sworn Statement of Emanuel Jones 2pgs.
29. Sworn Statement of Frank Brooks 3pgs
30. Disciplinary report – Louis Fano 2 pg
31. Information Report – Frank Brooks 1pg
32. Deposition of Courtney Eichelberger Civil Docket No: 3:17-CV-00656-JWD-EWD dated November 8, 2019 and Exhibits.
33. Booking Records – Louis Fano 19pgs.
34. Transcripts of phone and visit logs – 45pgs.

35. Deposition of Daniel Hinton, Jr. Civil Action No. 3.17-CV-00656-JWD-EWD dated November 12, 2019 and Exhibits.
36. Logbook Video – Excel spreadsheet
37. Deposition of Sharon Saxton Allen dated June 19, 2019 and Exhibits.
38. Deposition and Exhibits of Dolores Alvarez Zadikian dated August 20, 2019.
39. Deposition of Miguel Alvarez dated August 20, 2019 and Exhibits.
40. Deposition of Maria Miriam Alvarez dated August 20, 2019 and Exhibits.
41. Deposition of Kimberly Khosravian dated September 12, 2019 and Exhibits.
42. Deposition of Brian Bennet dated October 4, 2019 and Exhibits.
43. Deposition of Vincent Bradley dated August 6, 2019 and Exhibits.
44. Deposition of Joseph Breeding and exhibits dated June 18, 2019.
45. Deposition of Dr. Charlie Bridges dated October 17, 2019 and Exhibits.
46. Deposition of Frank Brooks and exhibits dated October 17, 2019.
47. Deposition of Andrea Brown and exhibits dated June 18, 2019.
48. Deposition of Joyce Brown dated September 19, 2019 and Exhibits.
49. Deposition of Jasmyn Cage dated June 19, 2019 and Exhibits.
50. Deposition of Tonyala Cannon and exhibits dated September 12, 2019.
51. Deposition of William Daniel and exhibits dated October 2, 2019.
52. Deposition of Gregory Doane dated August 21, 2018 and Exhibits.
53. Deposition of Courtney Eichelberger and exhibits dated November 8, 2019.
54. Deposition of Carlos Fano dated August 9, 2019 and Exhibits.
55. Deposition of Vanessa Fano dated August 19, 2019 and Exhibits.
56. Deposition of Linda Freeman-Jones and exhibits dated August 6, 2019.
57. Deposition of Justin Freeman and exhibits dated July 16, 2019.
58. Deposition of Tamekka Green dated June 11, 2019 and Exhibits.
59. Deposition of Chad Guillot and exhibits dated October 18, 2019.
60. Deposition of Susan Hatfield dated July 22, 2019 and Exhibits.
61. Deposition of Daniel Hinton dated November 12, 2019 and Exhibits.
62. Deposition of Rudolph Hyde dated June 19, 2019 and Exhibits.
63. Deposition of Jolanda James and exhibits dated June 18, 2019.
64. Deposition of Natasha Jones and exhibits dated October 18, 2019.
65. Deposition of Jean Llovet and exhibits dated September 19, 2019.
66. Deposition of Troy McGee dated June 15, 2019 and Exhibits.
67. Deposition of Ronald Monroe dated July 15, 2019 and Exhibits.
68. Deposition of Carlo Musso dated September 30, 2019 and Exhibits.
69. Deposition of Cathy Schley and exhibits dated June 11, 2019.
70. Deposition of Johnny Scott dated July 16, 2019 and Exhibits.
71. Deposition of Bryan Simmons dated July 16, 2019 and Exhibits.
72. Deposition of Walter Smith and exhibits dated October 14, 2019.
73. Deposition of Beatrice Stines and exhibits dated October 3, 2019.
74. Deposition of Danielle Thomas dated June 19, 2019 and Exhibits.
75. Deposition of Gary Wilson and exhibits dated July 15, 2019.
76. Deposition of Maria Zavala dated August 19, 2019 and Exhibits.
77. Deposition of Rani Whitfield and exhibits dated November 11, 2019.
78. Corey Pittman declaration in Lamar Johnson case.
79. Marcus Williams declaration in Lamar Johnson case.
80. Byron Maxon declaration in Lamar Johnson case.
81. Turner Jackson declaration in Lamar Johnson case.
82. Travis Anderson declaration in Lamar Johnson case.

83. Broderick Samuel declaration in Lamar Johnson case.
84. Michael Lacour declaration in Lamar Johnson case.
85. Josh Boxie declaration in Lamar Johnson case.
86. Christopher Haney declaration in Lamar Johnson case.
87. Joseph Jones declaration in Lamar Johnson case.
88. Shawn Robinson declaration in Lamar Johnson case.
89. Lorenza McCutcheon declaration in Lamar Johnson case.
90. US DOJ, Bureau of Justice Statistics, "Mortality in Local Jails 2000-2014".
91. Farris, S. and Armstrong, A., Dying in East Baton Rouge Parish Prison; July 2018.
92. Deposition of Walter Smith, Exhibit 2.
93. HMA notes dated 2016.
94. PPt Draft 1 dated 2016.
95. Batia Notes – NCCHC Medical Standard dated April 2016.
96. Batia Notes – NCCHC Medical Standard Mental Health.
97. NCCHC Position Statement: Solitary Confinement (Isolation) dated April 2016.
98. Metro Council Meeting video, Jan. 14, 2015, Item 13P and Q Part I.
99. CorEMR-EBRP – Reports staff activity reports provided by CorrectHealth in discovery.
100. Select security logs and booking unit rosters from the Lewis litigation.
101. EBRPP lockdown board review.
102. Select security logs and booking unit rosters from the Lewis litigation, including "C.B. Inmates" Roster.

Testimony of Belinda Maley

Before the Homeland Security and Governmental
Affairs Committee (HSGAC) Permanent Subcommittee on Investigations (PSI)

Hearing on "U.S. Department of Justice's ("DOJ")
Implementation of the Death in Custody Reporting Act"

Thank you, Chairman Ossoff and Ranking Member Johnson, for the opportunity to testify before you today. My name is Belinda Maley and I am the mother of Matthew Loflin. I am testifying today because in 2014 my son died because authorities in the Chatham County Detention Center ("CCDC") denied basic medical care to him.

I. Introduction

Matthew Loflin, whom we called Matt, was my only child. Every parent on this committee knows the love we have for our children. Imagine losing any of your children to the criminal legal system, especially to one of its jails where I was never able to hold him, never able to touch him. I am here today to ask you to put yourself in my shoes, to imagine the heartache of watching your only child suffer in a jail, be denied necessary medical care, and die after being transported to a hospital. Matt's death highlights the importance of the Death in Custody Reporting Act ("DCRA"), and the need to count all deaths of people in our nation's jails and prisons. Such data is a vital part of oversight of America's criminal legal system.

On February 6, 2014, Matt was arrested for non-violent drug charges and booked into the CCDC, which serves as Savannah, Georgia's jail. Within days he started losing consciousness in his cell. On February 21, 2014, the jail's health care provider—Corizon Health, Inc. ("Corizon")—collected medical information on Matt and performed a physical examination. They administered an electrocardiogram, which showed results consistent with congestive heart failure. In spite of the finding, Corizon staff took no action to have Matt evaluated further, and failed to treat him immediately for his heart condition.

As detailed in the attached Complaint, *Exhibit A*, for the next 5-6 weeks Matt suffered from congestive heart failure and was denied medical care by Corizon. On April 7, 2014—two months after he arrived in the CCDC—Matt was finally transported to a cardiologist, who immediately sent Matt to the emergency room of a local hospital. Although he finally received appropriate medical care, the lack of adequate medical care at the CCDC damaged his heart so much that Matt coded several times and suffered irreversible brain damage. On April 24, 2014, life support was withdrawn and Matt died that night. My testimony will focus on what happened to my son and the deadly perils of privatized medical care in Savannah's jail.

II. Health Care That Prioritizes Profit Over Care

Documents provided by the CCDC and Corizon show that many in the jail *knew* that Matt needed medical care for his heart condition, and some recommended that Matt be transported to a hospital for care, but Corizon leadership prohibited it. Why? Because medical

care for Matt would diminish Corizon's profits.

Matt's jail records show the following:

--February 6, 2014: Matt arrested for non-violent drug charges and jailed in the CCDC.

--February 21: Corizon staff collect a medical history, perform a physical exam, and administer an electrocardiogram ("ECG") of Matt's heart activity. The ECG indicated that his heart rate was elevated (125 bpm) and showed results consistent with congestive heart failure. Corizon staff took no further action.

--March 3: Matt complains to sheriff's deputies that his heart was racing and that he could not sleep. Corizon nurse V. Black responds, notes a heart rate of 140 bpm and that Matt had signs of syncope (i.e. fainting). Black merely marks the file to be reviewed later and took no further action.

--March 4: Matt again complains of passing out, anxiety, and a racing heart rate. Corizon nurse M. Stokes responds but makes no notation of Matt's elevated heart rate or signs of syncope. Instead, she schedules a mental health appointment for March 6, 2014.

--March 5: Sheriff's deputies call a Signal 55—code for a sick person—for Matt after finding him unconscious and appearing to have difficulty breathing. Nurse Stokes again responded, only to note that the mental health appointment she scheduled the day before was still on the calendar. She provided no further medical care and left Matt in his cell.

--March 6: Matt is seen by someone in Corizon's mental health department and prescribed medication for anxiety. Matt declined the medication, however, because he knew that he did not have a mental health problem.

--March 19: Matt is found unconscious in his cell. Sheriff's deputies called Signal 55 and Corizon Nurse D. Thrift responds. She takes no action except marking the file to be reviewed later and left Matt in his cell.

--March 20: Matt is found unconscious in his cell. Sheriff's deputies called Signal 55. Nurse K. Smith responds, scheduled Matt for an appointment with a doctor, gave him an additional blanket, and provided no further medical care. Later that day Matt had a chest x-ray which was read by Dr. Merrill Berman. The results showed that Matt had an enlarged heart (cardiomegaly) and pneumonia. The chart also notes that Matt was "coughing up blood," had a heart rate of 121, and had swelling of his feet.

--March 22: Matt complains to both security and Corizon that they were "covering up symptoms and not treating them."

--March 24: Matt is transferred to the medical unit of the CCDC and seen by Dr. Charles Pugh, the Corizon doctor at the CCDC. Dr. Pugh determined that Matt needed to be sent to the hospital. Corizon's policies, however, did not permit Dr. Pugh to send patients to

the hospital without the approval of the Regional Medical Director, Scott Kennedy. Dr. Kennedy works in the Corizon regional office located in Punta Gorda, Florida. Dr. Kennedy never personally observed, evaluated, or interacted with Matt. Kennedy overruled Dr. Pugh and refused to allow Matt to be sent to the hospital. Dr. Kennedy did approve, however, a referral for an outpatient echocardiogram for Matt.

--March 27: Matt is sent for an outpatient echocardiogram and testing. The test was performed, Matt was returned to the CCDC, and the results were sent to Dr. Pablo Elizalde, a cardiologist, for evaluation. In addition, Nurse Susan West wrote a progress note that indicated that Matt was faking his illness by "wretching (sic) neck all positions appearing to try to get himself to cough." Finally, she notes that Matt "stood up at the flap [and] yelled because he wants to know what we are gonna do for him that he can't breathe...observed yelling and stating that he has a heart condition."

--March 28: Dr. Elizalde informed Dr. Pugh that the results of the echocardiogram were consistent with the diagnosis of congestive heart failure. Matt had an Ejection Fraction of 10-15%, and his medical condition was acute. Dr. Pugh informed Dr. Kennedy of the results and requested authority to send Matt to the hospital. Dr. Kennedy again refused. At the end of the day, a 10:53 pm, Nurse Debra Thrift wrote a progress note indicating that Matt stated he was in constant pain, grabbed his chest, and rated his pain as a 10 on the 10 scale. Matt also said to the nurse, "[I am] not going to make it."

--March 29: Nurse Debra Thrift wrote another progress note indicating that Matt was "demanding to be taken to a hospital."

The documents show that each morning from March 28 through April 7, Dr. Pugh, Nurse Williams, and Nurse Riner informed their supervisor, Virginia O'Neill, that Matt needed hospitalization. Each day, Matt's medical condition declined. Each day, Ms. O'Neill refused to intervene and refused to send Matt to the hospital. Finally, on April 7, Dr. Pugh determined that he could send Matt to a cardiologist because Dr. Kennedy would only approve a cardiology consult, and he could get Matt to the hospital through the cardiology visit. The plan worked, and on April 7 Matt was sent to the Memorial Hospital Emergency Department. Treatment efforts failed, however, and on April 24 my husband and I said goodbye to my son.

The horror of what happened to Matt was knowing he was in such pain and knowing Corizon's supervisors did not care. On March 24 I was called by a stranger, a woman whose son was in the cell next to my Matt. The person in that cell relayed that Matt was not getting needed medical care, needed to go to the hospital, and was afraid he was going to die.

I called the jail to schedule a visit with my son and was informed that I could not see him until April 1 because his unit only allowed visitation on Tuesdays. When I finally saw Matt, I was shocked—it was clear that he was deathly ill, disoriented, pale, and bloated. Matt told me that he needed to be taken to the hospital, that he did not want to die in jail, and that he loved me.

My husband and I immediately started calling jail authorities to demand that Matt be taken to a hospital. We were told that we had to speak to the sheriff himself, and when we made

that call, he never responded. We called the jail over twenty times to have Matt sent to the hospital. We were ignored.

The perversity of this entire nightmare is that Corizon rewards staff for denying lifesaving medical care to people in the jails and prisons in which it operates. We discovered that the Regional Medical Director for Corizon, Dr. Kennedy, convened weekly conference calls with the Site Medical Directors who report to him what patients have been sent to outside medical providers. I understand that Kennedy uses these calls to pressure the Site Medical Directors about such patients and pushes the Site Medical Directors to work to release patients on bond or rush their return from the hospital to reduce costs and increase Corizon's profits. To make matters worse, Dr. Kennedy is compensated with both a base salary and performance incentives. That is, Dr. Kennedy's pay increases as Corizon's profits increase. In 2014, the year Matt died as a result of having the misfortune of being booked into Savannah's jail, Dr. Kennedy received performance incentives and casually joked that he would be able to "buy some fine scotch" with the increased pay he received.

Conclusion

Thank you for the opportunity to testify before you today. I am here both because my son died in one of Georgia's jails and because I believe with all my heart that change is possible. Please continue to highlight the importance of the Death in Custody Reporting Act to identify deaths and develop solutions to avoid them in custody. Thank you.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF GEORGIA
SAVANNAH DIVISION

BELINDA LEE MALEY, individually, and on behalf of the ESTATE of MATTHEW CLINTON LOFLIN, deceased,	)	
Plaintiffs,	)	C/A No.: CV 416-060
v.	)	
CORIZON HEALTH, INC., a Delaware Corporation; CORIZON, LLC., a Missouri Limited Liability Company; CHATHAM COUNTY, a Georgia County; ROY HARRIS, in his capacity as Acting CHATHAM COUNTY SHERIFF; Estate of AL ST LAWRENCE; JOHN WILCHER, individually and in his capacity as CCDC Jail Administrator; SCOTT H. KENNEDY, M.D.; ADAMAR GONZALEZ, M.D.; VIRGINIA O'NEILL,	)	JURY TRIAL DEMANDED
Defendants.	)	

COMPLAINT

COMES NOW, Plaintiff, Belinda Lee Maley, individually and on behalf of the Estate of Matthew Clinton Mr. Loflin, deceased, by and through counsel, and files this action against the above-named Defendants, respectfully showing the Court as follows:

INTRODUCTION

1.

This is a civil rights action for relief from violations of rights guaranteed by the Fourth, Eighth and Fourteenth Amendments to the Constitution of the United States, Title 42, Section 1983 of the United States Code, the laws of the United States, and the laws of the State of Georgia.

2.

Matthew Loflin died because Defendants were deliberately indifferent to his serious medical need. Corizon, by and through its agents, chose to protect its own profits rather than preserve Mr. Loflin's life. The Chatham County Defendants, in turn, chose to ignore Mr. Loflin's cries for help and instead protected their private contractor.

3.

Defendant Corizon Health is contractually obligated to provide medical care to inmates detained at Chatham County Detention Center ("CCDC").

4.

For Fiscal Year 2014, Corizon's agreement with the County, structured according to an average daily population ("ADP") of 1650 inmates, provided that Corizon would be paid $5.07 million to provide medical services in the jail. Under the terms of the agreement, Corizon was compensated, according to an annual base cost schedule, at $422,852 per month, with an additional per diem premium if the ADP exceeded 1650. The cost to the taxpayers of providing medical care was approximately $256 per inmate per month.

5.

Whatever Corizon does not spend providing medical care it retains as profit under the terms of the agreement.

6.

The average daily population of the CCDC for calendar year 2014, as reported by the Chatham County Sheriff to GBI/GCIC was less than 1500 inmates. This 10% decrease in actual ADP over projected ADP should have corresponded to a 10% increase in Corizon's retained profits, while preserving Corizon's ability to fulfill its constitutional and contractual obligations to the inmates detained at the CCDC.

7.

The "keep what you do not spend" compensation structure provides Corizon with a direct, dollar-for-dollar incentive to deny medical care to inmates.

8.

During 2014, Corizon's executive and administrative teams deliberately engaged in a pattern of delaying medically necessary treatment for as long as possible in order to avoid responsibility for the costs of basic medical care. The primary motivation for Corizon's conduct was to enlarge its profit margin.

9.

At the 2014 Corizon annual meeting a Corizon utilization management official gave a presentation lasting approximately 1.5 hours. The focus of said presentation was how to save money. One of the topics emphasized was minimizing the number of emergency room referrals of jail inmates.

10.

Also at the 2014 Corizon annual meeting, the Corizon CEO, Dr. Woodrow Myers, took the stage. Myers told the audience that the primary function of Corizon was to make money and that he was not embarrassed to say it.

11.

Corizon's strategy to increase profit at the expense of patient care included Corizon's regional managers and executives denying local providers' requests for outpatient referral. This practice directly contradicts CCDC inmates' constitutionally protected right to receive treatment for serious medical needs.

12.

Matthew Loflin was one such inmate. After being detained at CCDC and evaluated by local staff including the site medical director, Mr. Loflin was identified as a patient in need of immediate hospitalization due to a serious cardiac condition.

13.

Corizon's Southeast Regional Medical Director, first Scott H. Kennedy then Adamar Gonzalez, repeatedly denied local staff requests to have Mr. Loflin sent to the hospital because any hospitalization had the potential to undermine Corizon's profit margin.

14.

As a proximate result of Corizon's preference for profits over patients, Matthew Loflin died. His mother, Belinda Maley, now brings this case on behalf of herself and on behalf of Mr. Loflin's Estate, to redress Mr. Loflin's wrongful death and Corizon's deprivation of Mr. Loflin's rights as guaranteed by the Constitution and laws of the United States and the state of Georgia.

JURISDICTION

15.

This Court has jurisdiction pursuant to 28 U.S.C. § 1331 as to the Plaintiffs' claims that arise under the Fourth, Eighth, and Fourteenth Amendments to the Constitution and laws of the United States, to wit 42 U.S.C. § 1983, and pursuant to § 1343, to redress the deprivation, under color of state law, of Plaintiffs' rights guaranteed by Constitution of the United States pursuant to § 1983 and § 1988.

16.

This Court also has supplemental jurisdiction over the state law claims, which arise from the same facts and circumstances, pursuant to 28 U.S.C. § 1367.

17.

Venue is properly laid in this Court pursuant to 28 U.S.C. § 1391.

PARTIES

18.

Plaintiff Belinda Lee Maley (hereinafter, "Belinda Maley," "Ms. Maley," or "Plaintiff") is the duly-appointed Administratrix of the Estate of Matthew Clinton Loflin, Deceased, Liberty County Probate Case No. 2014-A-204, and at all times relevant is, and was, a citizen of the United States of America, residing in the state of Georgia.

19.

Belinda Lee Maley is the mother of Matthew Loflin.

20.

In bringing this action against the above-named Defendants, Belinda Maley acts in her individual capacity as the mother of Matthew Loflin and in her representative capacity for the benefit of, and on behalf of, the Estate of Matthew Loflin, and the Decedent's next of kin.

21.

Prior to his death, Decedent Matthew Loflin was a citizen of the United States of America, residing in the state of Georgia, and entitled to the protections of the Constitution and laws of the United States and the Constitution and laws of the State of Georgia.

22.

Defendants CORIZON HEALTH, INC. and CORIZON, LLC—together, the "Corizon Defendants"—are Delaware and Missouri entities, respectively. Corizon Health, Inc. contracted with Chatham County, Georgia to provide physical and mental health care, screening, assessment, treatment, and attention to those inmates detained at the CCDC. Both Corizon Defendants may be served at their principal office address, 103 Powell Court, Brentwood, Tennessee 37027.

23.

Defendant CHATHAM COUNTY ("the County") is a political subdivision of the State of Georgia. The County entered into an agreement with the Corizon Defendants to provide inmate healthcare services at the CCDC.

24.

ROY HARRIS is a resident of the state of Georgia and can be served with process at 1050 Carl Griffin Dr., Savannah, GA 31405. He is sued in his official capacity as Acting CHATHAM COUNTY SHERIFF.

25.

JOHN WILCHER is a resident of Chatham County and the state of Georgia. He is sued individually and in his capacity as former Chatham County Detention Center Jail Administrator.

26.

At all times relevant to this Complaint, Al St Lawrence was Chatham County Sheriff. St Lawrence died on November 24, 2015. His estate, the ESTATE OF AL ST LAWRENCE is sued for claims arising from actions taken by St Lawrence in his individual capacity.

27.

SCOTT H. KENNEDY, M.D. is an individual and a resident of the state of Florida. At all times relevant to this Complaint, Dr. Kennedy was Regional Medical Director for Corizon. Upon information and belief, Dr. Kennedy may be served with process at 3217 Coventry N., Safety Harbor, Florida 34695.

28.

ADAMAR GONZALEZ, M.D. is an individual, and resident of the state of Florida, who at all times relevant to this Complaint was Regional Medical Director for Corizon. Upon information and belief, Dr. Gonzalez may be served with process at 2889 Spring Breeze Way Kissimmee, Florida 34744-9269.

29.

Upon information and belief, Defendant VIRGINIA O'NEILL is a resident of Chatham County and the state of Georgia, with a permanent residence at 3 South Point Cross, Savannah, Georgia 31411. At all times relevant to this Complaint, Defendant O'Neill was Corizon's Healthcare Service Administrator ("HSA") at Chatham County Detention Center.

FACTUAL ALLEGATIONS

30.

The Chatham County Sheriff's Office ("CCSO") and Chatham County ("the County") jointly operate the Chatham County Detention Center ("CCDC").

31.

Both the CCSO and the County have a legal obligation to provide medical care to the inmates who are either detained or incarcerated at the CCDC.

32.

The County contracted with Corizon Health, Inc. ("Corizon") for Corizon to provide medical care to the inmates at the CCDC.

33.

On February 6, 2014, Mr. Loflin was arrested for non-violent drug charges and transported to the CCDC.

34.

In mid-February, Mr. Loflin began losing consciousness in his jail cell. Deputies were called to his cell on February 10 for a "Signal 55" (i.e. unconscious inmate) and again on February 11 for a second Signal 55. After each of these initial events, CCSO staff responded, and Corizon staff evaluated Mr. Loflin's condition.

35.

On February 21, 2014, Corizon staff collected a medical history from Mr. Loflin and performed a physical exam on him.

36.

Also on February 21, 2014, Corizon staff administered an electrocardiogram ("ECG") of Mr. Loflin's heart activity. The ECG indicated that Mr. Loflin's heart rate was elevated (125 bpm) and showed results consistent with congestive heart failure. Despite this result, Corizon staff took no further action.

37.

On March 3, 2014, Mr. Loflin complained to CCSO staff that his heart was racing and that he could not sleep. A Corizon nurse, "V. Black," responded. She noted a heart rate of 140 bpm and that Mr. Loflin had signs of syncope (i.e. fainting). Despite these findings, Nurse Black merely marked the file to be reviewed later but took no further action. She left Mr. Loflin in his cell.

38.

On March 4, 2014, Mr. Loflin again complained of passing out, anxiety, and a racing heart rate, stating further that he needed to be seen by the medical staff. A second Corizon nurse, "M. Stokes," responded. Nurse Stokes made no notation of Mr. Loflin's elevated heart rate or signs of syncope. Instead, she scheduled a *mental* health appointment for March 6, 2014 and left Mr. Loflin in his cell.

39.

On March 5, 2014, CCSO staff called a third Signal 55 for Mr. Loflin after he became unconscious and appeared to be having difficulty breathing. Nurse Stokes again responded, only to note that the *mental* health appointment she scheduled the day before was still on the calendar. She provided no further medical care and left Matthew in his cell.

40.

At Mr. Loflin's mental health appointment on March 6, 2014, Corizon staff prescribed medication for anxiety. Mr. Loflin refused to take this medication, however, because he knew that he did not have a mental health problem. He had a serious physical medical need.

41.

On March 19, 2014 and March 20, 2014, Mr. Loflin again became unconscious in his cell. CCSO staff called Signal 55s on both days.

42.

On March 19, Nurse "D. Thrift" responded. Rather than take any action, Nurse Thrift merely marked the file to be reviewed later and left Mr. Loflin in his cell.

43.

On March 20, Mr. Loflin asked for medical care and stated "no one will help me." Nurse "K. Smith" scheduled Mr. Loflin for an appointment with a doctor, gave Mr. Loflin an additional blanket, but provided him no further medical care. A copy of the March 20, 2014 "General Sick Call" form is attached hereto as Exhibit "A."

44.

On March 20, 2014, Mr. Loflin had a chest x-ray which was read by Dr. Merrill Berman. The results showed that Mr. Loflin had an enlarged heart (cardiomegaly) and pneumonia. Mr. Loflin's chart also notes that he was "coughing up blood," had a heart rate of 121, and had swelling of his feet. All of these results were consistent with congestive heart failure. Despite these results, Corizon staff took no further action.

45.

On March 22, 2014, Mr. Loflin complained to staff at the CCSO and Corizon that they were "covering up symptoms and not treating them."

46.

On March 24, 2014, a woman named Betty McRae called Ms. Maley. She informed Ms. Maley that her husband, Darrell McRae, was in the cell next to Mr. Loflin. Mr. Loflin had asked Mr. McRae to have his wife get in touch with Ms. Maley and inform her that he (Mr. Loflin) was not being treated, needed to go to the hospital, and was afraid he was going to die. Mr. McRae told his wife that Mr. Loflin was yelling out for help but was receiving no help, and that this had been going on for some time.

47.

For more than one month after the ECG report indicated Mr. Loflin was suffering from congestive heart failure, Corizon's nursing staff prevented Mr. Loflin from being transferred to the medical unit. Finally, on or about March 24, 2014 Mr. Loflin was transferred to the medical unit.

48.

On March 24, Mr. Loflin was evaluated by Dr. Charles Pugh, the Corizon doctor at the CCDC.

49.

Upon his initial evaluation, Dr. Pugh determined that Mr. Loflin needed to be sent to the hospital.

50.

Corizon's policies, however, did not permit Dr. Pugh to send Mr. Loflin to the hospital without the approval of the Regional Medical Director, Scott Kennedy.

51.

Dr. Kennedy works in the Corizon regional office located in Punta Gorda, Florida.

52.

As Regional Medical Director for Corizon, Kennedy convenes a conference call at least once per week with the Site Medical Directors reporting to him what patients have been sent to outside medical providers.

53.

Kennedy uses these calls to "woodshed" the Site Medical Directors about such patients and to determine if those patients can be released on bond or brought back from the hospital in order to reduce costs.

54.

Kennedy is compensated with both a base salary and performance incentives. Kennedy's pay increases as Corizon's profits increase.

55.

In 2014 Kennedy received such performance incentives and casually joked that he would be able to "buy some fine scotch" with the increased pay he received.

56.

Dr. Kennedy never personally observed, evaluated, or interacted with Mr. Loflin.

57.

Kennedy overruled Dr. Pugh and refused to allow Mr. Loflin to be sent to the hospital. Dr. Kennedy would only approve Mr. Loflin being referred for an outpatient echocardiogram.

58.

Dr. Pugh, Lynne Williams (who was the Corizon Physician Assistant), and Betty Riner (who was the Corizon Advanced Practice Registered Nurse), all informed their supervisor, Virginia O'Neill (the Corizon Health Services Administrator), that Mr. Loflin needed hospitalization.

59.

Defendant O'Neill refused to intervene, and Mr. Loflin was not sent to the hospital.

60.

On or about March 26, 2014, Ms. Maley called the jail to schedule a visit with her son. She was informed that she could not see him until April 1, 2014 because the unit only allowed visitation on Tuesdays.

61.

On March 27, 2014, Mr. Loflin was sent for an outpatient echocardiogram and testing. The test was performed. Mr. Loflin was returned to the CCDC. The results were sent to Dr. Pablo Elizalde, a cardiologist, for evaluation.

62.

On the same day, Nurse Susan West wrote a progress note that indicated that Mr. Loflin was faking his illness by "wretching (sic) neck all positions appearing to try to get himself to cough."

63.

The March 27 notes further indicate that Mr. Loflin "stood up at the flap yelled because he wants to know what we are gonna do for him that he can't breathe...observed yelling and stating that he has a heart condition." A copy of said Progress Notes are attached hereto as Exhibit "B."

64.

On March 28, 2014, Dr. Elizalde informed Dr. Pugh that the results of the echocardiogram were consistent with the diagnosis of congestive heart failure. Mr. Loflin had an Ejection Fraction of 10-15%, and his medical condition was acute.

65.

Dr. Pugh informed Dr. Kennedy of the results and requested authority to send Mr. Loflin to the hospital. Dr. Kennedy again refused to allow Mr. Loflin to be sent to the hospital. A copy of Dr. Pugh's chart notes for March 28, 2014, are attached hereto as Exhibit "C."

66.

Said chart notes read in pertinent part: "Spoke with mother after hipaa signed to report gravity of situation;" "Dr. Kennedy has agreed with outpatient cardiology referral, not ER;" and "Spoke with Dr. Elizalde, cardiologist, and he will see soon, but admits there's probably not much more he can do for him."

67.

Construing those sentences together, it is clear that Dr. Pugh knew Mr. Loflin's condition was grave but that Dr. Pugh was denied the ability to send Mr. Loflin to the ER. Rather, Dr. Pugh was only permitted to send Mr. Loflin back to Dr. Elizalde. However, Drs. Elizalde and Pugh didn't think there was much more that could be done in Dr. Elizalde's office than could be done at the jail.

68.

At 22:53 on March 28, 2014, Nurse Debra Thrift wrote a progress note indicating that Mr. Loflin stated he was in constant pain, grabbed his chest, and rated his pain as a 10 on the 10 scale. Mr. Loflin also said to the nurse, "[I am] not going to make it."

69.

On March 29, 2014, Nurse Debra Thrift wrote another progress note indicating that Mr. Loflin was "demanding to be taken to a hospital." A copy of the March 28 and March 29 Progress Notes are attached hereto as Exhibit "D."

70.

On April 1, 2014, Ms. Maley was permitted to visit with her son. There was a significant delay in Mr. Loflin appearing on the video screen. Maley was informed by the desk Sergeant that the staff were having "difficulties getting [Mr. Loflin] up" for the visit.

71.

Ms. Maley was shocked at Mr. Loflin's appearance and knew that he was deathly ill. He was disoriented, pale, and bloated. Mr. Loflin told his mother that he needed to be taken to the hospital, that he did not want to die in jail, and that he loved her.

72.

Ms. Maley and her husband, Joe Maley, immediately began demanding that Mr. Loflin be sent to the hospital.

73.

The Maleys spoke with Col. John Wilcher and explained the situation to him. Col. Wilcher told them to speak with Sheriff Al St Lawrence. Sheriff St Lawrence's assistant, Gretchen Derryberry, told the Maleys she would pass the information on to the Sheriff.

74.

Sheriff St Lawrence did not respond to the Maleys.

75.

Between March 24 and April 2, the Maleys placed or received twenty-three phone calls to the CCSO in their attempt to have Mr. Loflin sent to the hospital. However, despite the efforts of the Maleys, Mr. Loflin was not sent to the hospital.

76.

On April 2, 2014, Nurse Susan West made entries in Mr. Loflin's chart. Those entries show that at 00:30 Mr. Loflin stated that he "needed to go to the hospital" and "you all don't know what you are doing." At 02:41 Mr. Loflin demanded to go to the hospital. Nurse West told him no. CCSO Officer Dickens was present for this event. Mr. Loflin said "just wait 'til my family finds out you didn't take me to the hospital." Nurse West provided him with no further treatment and "left him fussing." A copy of said notes are attached hereto as Exhibit "E."

77.

Each morning from March 28 through April 7, Dr. Pugh, Ms. Williams, and Ms. Riner informed their supervisor, Virginia O'Neill, that Mr. Loflin needed hospitalization.

78.

Each day, Mr. Loflin's medical condition declined.

79.

Each day, Defendant O'Neill refused to intervene and refused to send Mr. Loflin to the hospital.

80.

Dr. Pugh determined that, because Dr. Kennedy would only approve a cardiology consult, he could send Mr. Loflin to the cardiologist and have the cardiologist admit Mr. Loflin to the hospital.

81.

Thus, on April 7, 2014, Mr. Loflin was sent to Cardiovascular Consultants of Savannah. Dr. Pugh notified them that Mr. Loflin was coming and needed hospitalization.

82.

Upon his arrival at Cardiovascular Consultants, Dr. Brett Burgess immediately sent Mr. Loflin to the Memorial Hospital Emergency Department.

83.

While in the emergency department Mr. Loflin's blood pressure declined, and he coded multiple times. After intensive medical treatment, Mr. Loflin was eventually stabilized cardiologically, but he had suffered irreversible brain damage.

84.

Life support was withdrawn on April 24, 2014, and Mr. Loflin died that night. A copy of the "Death Summary" written by Dr. Burgess is attached hereto as Exhibit "F."

COUNT I — Violation of 42 U.S.C.A. § 1983
(Sheriff's Policy or Custom of Deliberate Indifference)

85.

Plaintiff re-adopts, incorporates by reference, and re-alleges Paragraphs 1 through 84 as fully set forth above.

86.

Count I is brought against Defendant Harris in his official capacity as Acting Sheriff of Chatham County, pursuant to 42 U.S.C. § 1983, for deliberate indifference to the critical medical needs of Mr. Loflin, as an individual with an congestive heart failure that required testing and treatment to prevent substantial health deterioration and even death.

87.

The Sheriff knew in March 2014 that Mr. Loflin had a serious medical condition and that if the condition was not adequately monitored and addressed it could result in serious irreparable harm and even death.

88.

The Sheriff adopted a custom or practice of supporting Defendant Corizon's decision to avoid providing adequate medical care to inmates detained at CCDC.

89.

Despite knowledge of Mr. Loflin's serious medical needs, the Sheriff was deliberately indifferent to those serious medical needs in failing to direct Defendant Corizon to provide the necessary medical care and treatment to Mr. Loflin.

90.

The County and the CCSO have been aware that Corizon is deliberately indifferent to the medical needs of the inmates, provides poor care, and regularly violates the law in the execution of its contract with the County.

91.

At all times relevant to this Complaint, it was the Sheriff's widespread custom, policy, practice, and/or procedure to support Corizon's decisions to deny medical treatment of, or be deliberately indifferent to the serious medical needs of Plaintiff, and other prisoners/detainees incarcerated at the Chatham County Detention Center, who had serious and potentially expensive medical problems.

92.

As a direct and proximate result of the Sheriff's institutional outright denial of medical treatment and/or deliberate indifference toward Mr. Loflin's serious medical needs, Mr. Loflin suffered great physical injury, pain, discomfort and mental anguish in violation of his constitutional rights guaranteed by § 1983 and the Fourteenth Amendment.

93.

As a result, Mr. Loflin suffered damages in an amount be determined at trial. Plaintiff also seeks reasonable attorney's fees and costs, pre-judgment interest, and further relief as the Court deems appropriate.

WHEREFORE, Plaintiff respectfully requests this Court to (1) enter judgment declaring that the acts and omissions of Defendant Harris, as set forth above, violate rights secured to Mr. Loflin by the Fourth, Eighth, and Fourteenth Amendments to the Constitution of the United States, (2) that the Court award actual, compensatory, and punitive damages to Plaintiff, (3) the Court require Defendant Harris to pay the legal costs and expenses herein including reasonable attorney's fees, and (4) that the Court grant such further relief as it deems appropriate.

COUNT II — Violation of 42 U.S.C. § 1983
(Corizon's Deliberate Indifference to Mr. Loflin's Serious Medical Needs)

94.

Plaintiff re-adopts, incorporates by reference, and re-alleges Paragraphs 1 through 93 as fully set forth above.

95.

Count II is brought against Corizon Defendants pursuant to 42 U.S.C. § 1983 for deliberate indifference to the critical medical needs of Mr. Loflin, as an individual with a congestive heart failure who required testing and treatment to prevent substantial health deterioration and even death.

96.

Corizon and/or its employees or agents knew in March 2014 that Mr. Loflin had a serious medical condition and that if the condition was not adequately monitored and addressed it could result in serious irreparable harm and even death.

97.

By March 20, 2014, Corizon and/or its employees or agents, knew that Mr. Loflin was suffering from severe cardiologic problems and had lost the ability to walk.

98.

Despite knowledge of Mr. Loflin's serious medical needs, Corizon and its employees or agents were deliberately indifferent to those serious medical needs in failing to provide the necessary medical care and treatment to Mr. Loflin.

99.

Corizon and its employees or agents knew that taking no action and insufficient action could result in the rapid and permanent deterioration of Mr. Loflin's health and even his death.

100.

At all times relevant to this Complaint, it was Corizon's widespread custom, policy, practice, and/or procedure to outright deny medical treatment of, or be deliberately indifferent to the serious medical needs of, Mr. Loflin and other inmates detained or incarcerated at the Chatham County Detention Center who had serious and potentially expensive medical problems.

101.

As a direct and proximate result of Corizon's institutional outright denial of medical treatment and/or deliberate indifference toward Mr. Loflin's serious medical needs, Mr. Loflin suffered great physical injury, pain, discomfort, and mental anguish in violation of his constitutional rights guaranteed by § 1983 and the Fourteenth Amendment.

102.

As a result, Mr. Loflin suffered damages in an amount be determined at trial. Plaintiff also seeks reasonable attorney's fees and costs, pre-judgment interest, and further relief as the Court deems appropriate.

WHEREFORE, Plaintiff respectfully requests this Court to (1) enter judgment declaring that the acts and omissions of Defendant Corizon, as set forth above, violate rights secured to Mr. Loflin by the Fourteenth Amendment to the Constitution of the United States, (2) that the Court award actual, compensatory, and punitive damages to Mr. Loflin, (3) the Court require Defendant Corizon to pay the legal costs and expenses herein including reasonable attorney's fees, and (4) that the Court grant such further relief as it deems appropriate.

COUNT III — Violation of 42 U.S.C. § 1983

(Individual Corizon Defendants)

103.

Plaintiff re-adopts, incorporates by reference, and re-alleges Paragraphs 1 through 97 as fully set forth above.

104.

Count III is brought against Defendants Kennedy, Gonzalez, and O'Neill pursuant to 42 U.S.C. § 1983 for deliberate indifference to the critical medical needs of Mr. Loflin, as an individual with congestive heart failure that required testing and treatment to prevent substantial health deterioration and even death.

105.

Each individual Corizon defendant knew in March 2014 that Mr. Loflin was suffering from a serious medical condition and that if the condition was not adequately monitored and addressed it could result in serious irreparable harm and even death.

106.

As a direct and proximate result of the individual Corizon Defendants' denial of medical treatment and/or deliberate indifference toward Mr. Loflin's serious medical needs, Mr. Loflin suffered great physical injury, pain, discomfort, and mental anguish in violation of his constitutional rights guaranteed by § 1983 and the Fourteenth Amendment.

107.

As a result, Mr. Loflin suffered damages in an amount be determined at trial. Plaintiff also seeks reasonable attorney's fees and costs, pre-judgment interest and further relief as the Court deems appropriate.

WHEREFORE, Plaintiff respectfully requests this Court to (1) enter judgment declaring that the acts and omissions of the individual Corizon Defendants, as set forth above, violate rights secured to Mr. Loflin by the Fourth, Eighth, and Fourteenth Amendments to the Constitution of the United States, (2) that the Court award actual, compensatory, and punitive damages to Mr. Loflin, (3) the Court require individual Corizon Defendants to pay the legal costs and expenses herein

including reasonable attorney's fees, and (4) that the Court grant such further relief as it deems appropriate.

COUNT IV — Violation of 42 U.S.C. § 1983

(Individual County Defendants)

108.

Plaintiff re-adopts, incorporates by reference, and re-alleges Paragraphs 1 through 107 as fully set forth above.

109.

Count IV is brought against Defendants Estate of Al St Lawrence and John Wilcher pursuant to 42 U.S.C. § 1983 for deliberate indifference to the critical medical needs of Mr. Loflin, as an individual with congestive heart failure who required testing and treatment to prevent substantial health deterioration and even death.

110.

Each individual County defendant knew in March 2014 that Mr. Loflin was suffering from a serious medical condition and that if the condition was not adequately monitored and addressed it could result in serious irreparable harm and even death.

111.

As a direct and proximate result of the individual County Defendants' denial of medical treatment and/or deliberate indifference toward Mr. Loflin's serious medical needs, Mr. Loflin suffered great physical injury, pain, discomfort, and mental anguish in violation of his constitutional rights guaranteed by § 1983 and the Fourteenth Amendment.

112.

As a result, Mr. Loflin suffered damages in an amount be determined at trial. Plaintiff also seeks reasonable attorney's fees and costs, pre-judgment interest and further relief as the Court deems appropriate.

WHEREFORE, Plaintiff respectfully requests this Court to (1) enter judgment declaring that the acts and omissions of the individual County Defendants, as set forth above, violate rights secured to Mr. Loflin by the Fourth, Eighth, and Fourteenth Amendments to the Constitution of the United States, (2) that the Court award actual, compensatory, and punitive damages to Mr. Loflin, (3) the Court require individual County Defendants to pay the legal costs and expenses herein including reasonable attorney's fees, and (4) that the Court grant such further relief as it deems appropriate.

COUNT V — Wrongful Death
(All Defendants)

113.

Plaintiff re-adopts, incorporates by reference, and re-alleges Paragraphs 1 through 112 as fully set forth above.

114.

As is more fully described above, Mr. Loflin's death was preventable. Yet each of the defendants herein failed or refused to fulfill their obligation to provide him with medical care. Mr. Lofin died as a result of the criminal, intentional, and negligent acts of each of the Defendants.

115.

As a direct and proximate result of the Defendants' wrongful acts, Matthew Loflin died by homicide.

116.

Mr. Loflin's death was a wrongful death within the meaning of the Georgia Wrongful Death Act, Ga. Code Ann. § 51-4-1, *et seq*. Section 51-4-4 provides a right of action for the wrongful death of a child killed by homicide.

117.

Under Ga. Code Ann. § 19-7-1(c)(2)(A), Plaintiff Belinda Maley is a parent entitled to prosecute this right of action.

WHEREFORE, Belinda Maley seeks judgment against the Defendants, jointly and severally, for: (a) the full value of the life of Matthew Loflin; (b) the costs of suit and reasonable attorney's fees; and (c) that the Court grant such further relief as it deems appropriate.

{Signatures appear on following page.}

RESPECTFULLY SUBMITTED, this 22nd day of February, 2016

/s/ William R. Claiborne
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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF GEORGIA
SAVANNAH DIVISION

BELINDA LEE MALEY, individually, and on behalf of the ESTATE of MATTHEW CLINTON MR. LOFLIN, deceased,	)	
Plaintiffs,	)	C/A No.:
v.	)	
CORIZON HEALTH, INC., a Delaware Corporation; CORIZON, LLC., a Missouri Limited Liability Company; CHATHAM COUNTY, a Georgia County; ROY HARRIS, in his capacity as Acting CHATHAM COUNTY SHERIFF; Estate of AL ST. LAWRENCE; JOHN WILCHER, individually and in his capacity as CCDC Jail Administrator; SCOTT H. KENNEDY, M.D.; ADAMAR GONZALEZ, M.D.; VIRGINIA O'NEILL,	)	
Defendants.	)	

Exhibit A

CORIZON
Nursing Encounter Tool
General Sick Call

Silent Signal 05

Facility Name CCDC	Location Seen	Date seen 3/20/2014	Time Seen ○ AM ○ PM 00:59
Patient's Name: Last LOFLIN	First MATTHEW	MI	ID Number 20140202271 Birth date 10/30/1981
Medication Allergies ☒ N ○ Y If Yes List:			
Chronic Care Clinic(s) ○ N ☒ Y			Last seen in Sick Call: 2/19/14 ☐ N/A
☐ Seizures ☐ Asthma ☐ CAD ☐ Dyslipidemia			
☐ DM ☐ COPD ☐ HTN ☒ Other Hep C			

SUBJECTIVE

Chief complaint with onset: Extreme pain, coughing, fever, chest pain, swollen feet

History of chief complaint: x 4 days "no one will help me"

Associated symptoms: abdominal pain, coughing, hot + cold

☐ None

OTC Medications: ☒ N ○ Y: List

New Medication or change in last 30 days ☒ N ○ Y: List

Pertinent past medical history: hernia, hep c

OBJECTIVE

Vital Signs: T 96.7 P 68 RR 21 BP 124/72 FSBG (If diabetes) Wt. Pulse Ox 100 %

General appearance: Acute distress ☒ N ○ Y: Describe

Skin: Cool ○ N ☒ Y Clammy ☒ N ○ Y Pale ☒ N ○ Y

Eyes: Conjunctiva pale ☒ N ○ Y Sclera icteric ☒ N ○ Y

Additional examination: BS present x4, Bilat Lungs CTA, non productive cough, abd tender LLQ, Bilat feet cold to touch, mottled, pitting edema present, pedal pulses weakly but present, no capillary refill, Bilat legs tender - entire leg

Nurse's Signature	Print/Stamp	Title
K Smith	K Smith	LPN

NA6245
Issued 1/15/2013

CORIZON

Nursing Encounter Tool
General Sick Call

Patient's Name	Last LOFLIN	First MATTHEW	MI	ID Number 2014020271

☒ Emergent intervention not required. ○ Emergent intervention required due to:

Notify practitioner after EMS activation due to
Describe:_____

EMS process activated Time:_____ ○ AM ○ PM
EMS Arrival Time:_____ ○ AM ○ PM
EMS Transport Time:_____ ○ AM ○ PM
Consider: ☐ O_2 ☐ AED ☐ CPR
☐ Other:_____

Practitioner notified:_____ Time:_____ ○ AM ○ PM

○ Urgent intervention not required. ☒ Urgent intervention required due to:

Practitioner contact required for: (check all that apply)

☐ Vital signs:_____
☐ Unimproved or worsening symptoms
☐ Clammy
☐ Pale
☐ Jaundice
☐ Altered mental status
☒ Other: Dec Ret
○ Seen by Practitioner ○ Contacted Practitioner
Name: provider Sick call ochsal
05/20/14
Time:_____ ○ AM ○ PM

See physician orders

Disposition
☐ Same day practitioner visit/consult
☐ Monitor:_____
☐ Admit to:_____
☐ Other:_____
☐ Sick call follow up: ○ Practitioner ○ Nurse
☐ Transport via:_____ to_____
Time:_____ ○ AM ○ PM

○ Routine intervention

Disposition:
Medical referral required for: (check all that apply)

☐ Recurrent complaint(2 x 72 hours) without urgent findings
☐ Medication review
☐ Other:_____
○ Practitioner referral completed
○ Chart designated for practitioner review
○ No Medical Referral Required

Interventions: (check all that apply)

OTC medication given per guidelines ○ N ○ Y
☐ Medication:_____ ☐ KOP
☐ Other:_____

Xtra blanket given for night to elevate legs

Contact a practitioner or nursing supervisor if you have any concerns about the status of the patient.

Patient Education	Follow Up/Follow Through
☒ Patient educated to contact medical if symptoms develop or worsen ☐ Written information provided ☒ The patient demonstrates an understanding of self-care, symptoms to report and when to return for follow-up care.	Nurse follow up scheduled ☒ N ○ Y Custody notified of special needs ☒ N ○ Y

Nurse's Signature	Print/Stamp	Title
K Smith	K Smith	LPN

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF GEORGIA
SAVANNAH DIVISION

BELINDA LEE MALEY, individually, and on behalf of the ESTATE of MATTHEW CLINTON MR. LOFLIN, deceased,	)	
Plaintiffs,	)	C/A No.:
v.	)	
CORIZON HEALTH, INC., a Delaware Corporation; CORIZON, LLC., a Missouri Limited Liability Company; CHATHAM COUNTY, a Georgia County; ROY HARRIS, in his capacity as Acting CHATHAM COUNTY SHERIFF; Estate of AL ST. LAWRENCE; JOHN WILCHER, individually and in his capacity as CCDC Jail Administrator; SCOTT H. KENNEDY, M.D.; ADAMAR GONZALEZ, M.D.; VIRGINIA O'NEILL,	)	
Defendants.	)	

Exhibit B

Chatham County | Name: LOFLIN, MATTHEW | Arrest #: 2014020271

Facility: CCDC | DOB: 10/30/1981 | DIN #: 65011088

Housing: TRAH_, TRAH

Progress Note

Note Detail

Event: Other | Event Date: 3/27/2014 | Service: Infirmary/Observation

Note Type: NARRATIVE | Entered in Error: No

Narrative: 0000AM OBSERVED SITTING UP ON SIDE OF BED.. WRETCHING NECK ALL POSITIONS APPPEARING TO TRY TO GET HIMSELF TO COUGH.. THEN OBSERVED NERVOUS TIC OF HIS RIGHT LEG AND ARM AS IF ALMOST SEIZURE LIKE NO COUGHING.. THEN FINALLY GOT A CUP OF WATER DRANK ENTIRE CUP THEN ACTED AS IF HE WAS GONNA FALL OVER AND LAID ON RIGHT SIDE AT FOOT OF BED.. STARTED COUGHING THEN.
Keyed By: West RN, Susan on Friday, March 28, 2014 / 00:21

Vitals Detail

Date	Time	Temperature	Pulse	Respiration	BP	Finger Stick	Pulse Ox	Peak Flow	Height	Weight

Added by West RN, Susan 3/28/2014 00:21

Note Detail

Event: Other | Event Date: 3/27/2014 | Service: Infirmary/Observation

Note Type: NARRATIVE | Entered in Error: No

Narrative: 1155 PM OBSERVED ON MONITOR HOLDING HIS BREATH THEN WHEN NO LONGER CAN HOLD BREATHES AND CALLS OUT FOR HELP..SECURITY WILL NOT ALLOW ME TO GO TO HIS BEDSIDE THEY ARE TALKING TO HIM NOW.
Keyed By: West RN, Susan on Friday, March 28, 2014 / 00:05

Vitals Detail

Date	Time	Temperature	Pulse	Respiration	BP	Finger Stick	Pulse Ox	Peak Flow	Height	Weight

Added by West RN, Susan 3/28/2014 00:05

Chatham County | Name: LOFLIN, MATTHEW | Arrest #: 2014020271

Facility: CCDC | DOB: 10/30/1981 | DIN #: 85011088

Housing: TRAH_, TRAH

Progress Note

Note Detail

Event: Other | Event Date: 3/27/2014 | Service: Infirmary/Observation

Note Type: NARRATIVE | Entered in Error: No

Narrative: CALLED L. WILLIAMS PA BECAUSE OF ROWDY BEHAVIOR AND NEED TO MONITOR BUT KEEPING ROOMMATES AWAKE AND CURSING.. CALLED WATCH COMMANDER AND GIVEN PERMISSION TO MOVE TO ANOTHER CELL..WALKED TO FEMALE ISO 2.. CHEST CLEAR BILATERALLY VSS..WILL CONTINUE TO MONITOR.
Keyed By: West RN, Susan on Friday, March 28, 2014 / 01:08

Vitals Detail

Date	Time	Temperature	Pulse	Respiration	BP	Finger Stick	Pulse Ox	Peak Flow	Height	Weight

Added by West RN, Susan 3/28/2014 01:08

Note Detail

Event: Other | Event Date: 3/27/2014 | Service: Infirmary/Observation

Note Type: NARRATIVE | Entered in Error: No

Narrative: 0020 OBSERVED FROM MONITOR.. STOOD UP AT FLAP YELLED BECAUSE HE WANTS TO KNOW WHAT WE ARE GONNA DO FOR HIM THAT HE CAN'T BREATHE..OBSERVED YELLING AND STATING HE HAS A HEART CONDITION.. NOT YET DOCUMENTED.. STANDING AT THE FLAP..
Keyed By: West RN, Susan on Friday, March 28, 2014 / 00:29

Vitals Detail

Date	Time	Temperature	Pulse	Respiration	BP	Finger Stick	Pulse Ox	Peak Flow	Height	Weight

Added by West RN, Susan 3/28/2014 00:29

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF GEORGIA
SAVANNAH DIVISION

BELINDA LEE MALEY, individually, and on behalf of the ESTATE of MATTHEW CLINTON MR. LOFLIN, deceased,	)	
Plaintiffs,	)	C/A No.:
v.	)	
CORIZON HEALTH, INC., a Delaware Corporation; CORIZON, LLC., a Missouri Limited Liability Company; CHATHAM COUNTY, a Georgia County; ROY HARRIS, in his capacity as Acting CHATHAM COUNTY SHERIFF; Estate of AL ST. LAWRENCE; JOHN WILCHER, individually and in his capacity as CCDC Jail Administrator; SCOTT H. KENNEDY, M.D.; ADAMAR GONZALEZ, M.D.; VIRGINIA O'NEILL,	)	
Defendants.	)	

Exhibit C

CORIZON
Promote a culture of safety

Progress Note

Name:	Lyles		
Date of Birth:		ID #:	

Date	Time	Description	Signature/Title
3-27-14 8AM		What to keep quietly late while pt thinks about on status —	
		Good thing not did.	
		They are asking him for ⊖ Rule LE venous US & didn't	
		see report for taking US or ECHO.	
		Was taking US would send out, GR thinking but no ...	
		no ... or hepatic ...	
		ECHO is pending.	
		... report of all to follow.	
		For CHF ... labs should be ...	
		98.1 120 16 100/71	
		[illegible signature]	
		CXR — still large cardiomegaly but	
		not clearing all —	
		[illegible signature]	
3-28-14 9:45am	S/	Pt about same — anxious.	
		No coughing now — afebrile. Legs ... but ...	
	O/	... T bili 1.69 ALT 870/AST 671. BUN 32/Scr 1.24	K 4.4
		... 3.1 alk phos 128	
		HIV⊖ CBC nl uric acid 9.2	
		1+ edema ... — ... off. 97.6	CXR - massive cardiomegaly
		CV - ...	
		chest — fairly clear — ...	ECHO - global hypokinesis LVEF 10-15%
	A/	... cardiomyopathy - LVEF 10-15% - global hypokinesis	P/ ...
		...	...

COMPLETE BOTH SIDES BEFORE USING ANOTHER SHEET

CORIZON
Promote a culture of safety

Progress Note

Name: Loflin [illegible] Matthew
Date of Birth: ID #:

Date	Time	Description	Signature/Title
3-28-14 (Cont'd)		Spoke ē [illegible] ū HIPPA signed & report [illegible]	
		Dr Kennedy has agreed ē [illegible] Cardiology Referral, not ER.	
		Pt on [illegible], [illegible] will ↓ [illegible] ē 2a	
	3PM	Spoke ē Dr [illegible], Cardiology, & he will see soon, but [illegible] there's probably not much more he can do for him.	
		CAB [illegible]	
3-31-14	6:30 pm	S/ Pt [illegible]. [illegible] he's [illegible].	
		[illegible] cough in [illegible] (Lisinopril held on weekend ē ↓ BP)	
		O/ Good urine output 97.9 HR ↓ 103 R 16 BP 87/67	O₂ at [illegible] 100%
		chest [illegible] — [illegible] ® [illegible]	
		CV - RR, [illegible].	
		[illegible] A, Ox3.	
		A/ Cardiomyopathy — end stage	
		[illegible]	P/ Repeat DP-1
		CHF -	↓ [illegible] (by 2a)
			[illegible] Lisinopril ' [illegible].
			Cont [illegible], TEDS, [illegible].
			Cardiology consult pending.
		CAB [illegible]	
4-1-14	10:15 am	S/ Father called earlier. [illegible] HIPPA form ! [illegible] called him back.	
		Pt [illegible] ' [illegible] he's [illegible].	
		DOE -	
		O/ CV-RR, [illegible].	
		Chest [illegible] - [illegible] ® [illegible]	
		[illegible] A, Ox3	P/ [illegible], DP-1 [illegible].
		[illegible] - [illegible]	

A/ As above

COMPLETE BOTH SIDES BEFORE USING ANOTHER SHEET CAB [illegible]

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF GEORGIA
SAVANNAH DIVISION

BELINDA LEE MALEY, individually, and on behalf of the ESTATE of MATTHEW CLINTON MR. LOFLIN, deceased,	)	
Plaintiffs,	)	C/A No.:
v.	)	
CORIZON HEALTH, INC., a Delaware Corporation; CORIZON, LLC., a Missouri Limited Liability Company; CHATHAM COUNTY, a Georgia County; ROY HARRIS, in his capacity as Acting CHATHAM COUNTY SHERIFF; Estate of AL ST. LAWRENCE; JOHN WILCHER, individually and in his capacity as CCDC Jail Administrator; SCOTT H. KENNEDY, M.D.; ADAMAR GONZALEZ, M.D.; VIRGINIA O'NEILL,	)	
Defendants.	)	

Exhibit D

Chatham County | Name: LOFLIN, MATTHEW | Arrest #: 2014020271

Facility: CCDC | DOB: 10/30/1981 | DIN #: 85011088

Housing: TRAH_, TRAH

Progress Note

Note Detail

Event: Other | Event Date: 3/29/2014 | Service: Infirmary/Observation

Note Type: NARRATIVE | Entered in Error: No

Narrative: INMATE YELLING OUT IN CELL. DEMANDING TO BE TAKEN TO THE HOSPITAL. ADVISED TO CALM DOWN AND RELAX IN BED. ADVISED ON CALL PROVIDER HAS BEEN NOTIFIED AND IS AWARE OF HIS CONDITION. ADVISED OF MED CHANGE FOR AM. WILL CONTINUE TO MONITOR.
Keyed By: Thrift, Debra on Saturday, March 29, 2014 / 00:13

Vitals Detail

Date	Time	Temperature	Pulse	Respiration	BP	Finger Stick	Pulse Ox	Peak Flow	Height	Weight

Added by Thrift, Debra 3/29/2014 00:13

Note Detail

Event: Other | Event Date: 3/28/2014 | Service: Infirmary/Observation

Note Type: NARRATIVE | Entered in Error: No

Narrative: COMPLAINT OF CHEST PAIN. HOLDING HIS HAND OVER LT. BREAST AREA. STATES PAIN IS CONSTANT, SHARP STABBING PAIN. RATES PAIN AS A 10 ON A SCALE OF 1-10. HYPERVENTILATING. STATES HE IS NOT GOING TO MAKE IT. SKIN WARM AND DRY TO TOUCH. ALERT AND ORIENTED. DENIES ANY RADIATION OF PAIN, STATES IT IS STATIONARY. ON CALL PROVIDER CALLED. REPORT GIVEN. ADVISED TO HOLD LISINOPRIL IN AM AND MONITOR. OFFER REASSURANCE AS NEEDED.
Keyed By: Thrift, Debra on Friday, March 28, 2014 / 23:02

Vitals Detail

Date	Time	Temperature	Pulse	Respiration	BP	Finger Stick	Pulse Ox	Peak Flow	Height	Weight
3/28/2014	22:53		114 - P	24	80/60					

Added by Thrift, Debra 3/28/2014 23:02

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF GEORGIA
SAVANNAH DIVISION

BELINDA LEE MALEY, individually, and on behalf of the ESTATE of MATTHEW CLINTON MR. LOFLIN, deceased,	)	
Plaintiffs,	)	C/A No.:
v.	)	
CORIZON HEALTH, INC., a Delaware Corporation; CORIZON, LLC., a Missouri Limited Liability Company; CHATHAM COUNTY, a Georgia County; ROY HARRIS, in his capacity as Acting CHATHAM COUNTY SHERIFF; Estate of AL ST. LAWRENCE; JOHN WILCHER, individually and in his capacity as CCDC Jail Administrator; SCOTT H. KENNEDY, M.D.; ADAMAR GONZALEZ, M.D.; VIRGINIA O'NEILL,	)	
Defendants.	)	

Exhibit E

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF GEORGIA
SAVANNAH DIVISION

BELINDA LEE MALEY, individually, and on behalf of the ESTATE of MATTHEW CLINTON MR. LOFLIN, deceased,	)	
Plaintiffs,	)	C/A No.:
v.	)	
CORIZON HEALTH, INC., a Delaware Corporation; CORIZON, LLC., a Missouri Limited Liability Company; CHATHAM COUNTY, a Georgia County; ROY HARRIS, in his capacity as Acting CHATHAM COUNTY SHERIFF; Estate of AL ST. LAWRENCE; JOHN WILCHER, individually and in his capacity as CCDC Jail Administrator; SCOTT H. KENNEDY, M.D.; ADAMAR GONZALEZ, M.D.; VIRGINIA O'NEILL,	)	
Defendants.	)	

Exhibit E

Chatham County | Name: LOFLIN, MATTHEW | DOB: 10/30/1981 | Arrest #: 2014020271
Facility: CCDC | DIN #: 55011086

Vitals

04/03/2014	08:34	97.7	102	18	86/60		209	
04/02/2014	21:22	97.8	103	20	96/60	97		
04/02/2014	07:35		112	14	92/67	88		
04/02/2014	02:41		56	18				
04/02/2014	00:30		60	22				

Type: NARRATIVE
Narrative: LYING IN BED AWAKE AND ALERT. REQUESTING ICE AND JUICE. 250CC AMBER COLORED URINE EMPTIED FROM URINAL. REMINDED OF NEED TO MEASURE ALL URINS. STICT I&O. VERBALIZES UNDERSTANDING. SKIN WARM AND DRY TO TOUCH. LOWER EXTREMITIES REMAIN SWOLLEN. ENCOURAGED TO KEEP ELEVATED. TED HOSE ON. CUP WITH TISSUE WITH BLOOD TINGED SPUTUM NOTED AT BEDSIDE. SPUTUM NOTED ON FLOOR. INMATE ENCOURAGED NOT TO SPIT ON FLOOR DUE TO INFECTION CONTROL ISSUE. VERBALIZES UNDERSTANDING. ICE AND JUICE GIVEN AS REQUESTED. RHONCHI SCATTERED THROUGHOUT LUNG FIELDS. NO ACUTE RESP. DISTRESS NOTED. WILL CONTINUE TO MONITOR AND OFFER ENCOURAGEMENT AS NEEDED.
Keyed By: Thrift, Debra on Wednesday, April 02, 2014 / 21:29

Type: NARRATIVE
Narrative: PT SITTING ON SIDE OF BED x4± TIMES THREE GAVE PT A REMINDERED TO KEEP LEG ELEVATED TO DECREASE SWELLING PT REFUSED WT. STATED HE DIDNT WANT TO WALK TO SCALE. NO ACUTE DISTRESS NOTED BREATH SOUNDS CLEAR. CONTIUE TO MONITOR. Keyed By: Cate RN, Leyelle on Wednesday, April 02, 2014 / 8:39 AM

Type: NARRATIVE
Narrative: OBSERVED EARLIER STAND UP ON SIDE OF BED WITH ALL CLOTHES UNSNAPPED.. THEN SAT ON SIDE OF BED.. STATES MY HEART HURTS.. WHEN TOLD HIM NO WE WERE NOT TAKING HIM TO THE HOSPITAL BECAUSE HIS HEART IS IN REGULAR RHYTHM..HE STATED MULTIPLE CUSS WORDS..SECURITY MS DICKENS TOLD NOT TO DISRESPECT NURSE BUT DID NOT STOP..GOT TO LISTEN TO HEART NO IRREGULARITY NOTED.. HE STATED JUST WAIT TIL MY FAMILY FINDS OUT YOU DONT TAKE ME TO THE HOSPITAL..LEFT HIM PUSHING BUT TOLD HIM HE WILL NOT BE ABLE TO SLEEP IF HE SLEEPS ALL DAY TOO.. Keyed By: West RN, Susan on Wednesday, April 02, 2014 / 2:45 AM

Type: NARRATIVE
Narrative: EMPTIED URINAL OF 600 DARK YELLOW URINE.. STATES I NEED TO GO TO HOSPITAL.. CHEST CLEAR HR 56 NO IRREGULARITY EXPLAINED THAT HE NEEDED TO INCREASE MOVEMENT IN BED SIT UP IF HE FELT BAD.. RR EVEN AND REGULAR.. YOU ALL DONT KNOW WHAT YOU ARE DOING.. OFFERED ORANGE AND REFUSED I WANT AN APPLE..WILL CONTINUE TO MONITOR. Keyed By: West RN, Susan on Wednesday, April 02, 2014 / 2:49 AM

Type: NARRATIVE
Narrative: AROUSED REQUESTING ENSURE.. TOLD HE COULD HAVE IF HE ATE SANDWICH.. GIVEN SANDWICH AND TOOK 4 BITES.. WATER, JUICE AND MONITORED NO OUTPUT AS YET.. NOTE HAD LOOSE BM EARLIER TODAY..LAID DOWN WHILE EATING WHEN THIS NURSE IN HE STATED HIS HEART WAS HURTING AND THAT HE WAS NOT GONNA TAKE BENEDRYL NOR XYLOCT..EXPLAINED AND INSTRUCTED THAT HE CAN

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF GEORGIA
SAVANNAH DIVISION

BELINDA LEE MALEY, individually, and on behalf of the ESTATE of MATTHEW CLINTON MR. LOFLIN, deceased,	)	
Plaintiffs,	)	C/A No.:
v.	)	
CORIZON HEALTH, INC., a Delaware Corporation; CORIZON, LLC., a Missouri Limited Liability Company; CHATHAM COUNTY, a Georgia County; ROY HARRIS, in his capacity as Acting CHATHAM COUNTY SHERIFF; Estate of AL ST. LAWRENCE; JOHN WILCHER, individually and in his capacity as CCDC Jail Administrator; SCOTT H. KENNEDY, M.D.; ADAMAR GONZALEZ, M.D.; VIRGINIA O'NEILL,	)	
Defendants.	)	

Exhibit F

[illegible]	00729363	[illegible]
BILLING #:	001409700409	University Medical Center Savannah, Georgia
DICTATING PHYSICIAN:	Brett C. Burgess, M.D.	
CO-SIGNING PHYSICIAN:		
ROOM AND BED:	CV01AEMR	
DATE OF BIRTH:	10/30/1981	

DEATH SUMMARY

DATE OF ADMISSION: 04/07/2014

DATE OF DEATH:

DATE OF DEATH
04/24/2014 at 8:15 p.m.

HOSPITAL COURSE
He presented as a new patient consult in my outpatient office. He is brought in from Chatham County Prison with complaints of shortness of breath. Patient had been complaining of increasing and worsening shortness of breath and significant orthopnea, as well as a cough for the past number of months. On 03/26/2014, he was sent for an elective outpatient echocardiogram at Memorial Hospital, which I interpreted as a severe global left ventricular hypokinesis with moderately dilated left ventricle and an ejection fraction of 10% to 15%. There is no obvious thrombus, and the right ventricle was enlarged and hypokinetic as well. There was mild functional mitral regurgitation and a small circumferential pericardial effusion noted. Pericardial effusion was not causing any echocardiographic evidence of hemodynamic compromise. On April 7th, he presented to my office as a new patient consult. He did appear acutely ill, short of breath, and somewhat diaphoretic. Based on the echocardiogram report and clinical findings, he appeared to be in congestive heart failure. He had significant lower extremity edema. While in our office, he coughed a small amount of blood. I determined that he needed inpatient admission. He was taken to the emergency room. At that time, his systolic blood pressure was low normal. He was mildly tachycardic. Initial diuresis was initiated with IV Lasix. While in the emergency department later that evening, his blood pressure started to decline. Chest x-ray results showed a significant right lower lobe effusion versus consolidation, as well as significant cardiomegaly and some pulmonary congestion. I consulted Pulmonary Critical Care for their assistance. A CT of his chest revealed enlarged heart. No mediastinal adenopathy. Lungs showed bilateral pleural effusions, greatest on the right, and scattered areas of consolidation predominantly at the bases. There was enhancement of pleura on the right, which may represent empyema. His blood pressure continued to deteriorate throughout the night requiring initiation of pressors. He was intubated because of altering mental status and concern about protecting his airway. Apparently, he developed PEA arrest around the time of intubation, and ACLS protocol was initiated. He will reportedly had a couple other occurrences of PEA arrest requiring ACLS. He was successfully resuscitated on numerous occasions, but required extensive pressors including norepinephrine, dopamine, dobutamine, and vasopressin, and his blood pressure was in the 60s systolic. I consulted Cardiothoracic Surgery, Dr. London to consider an Impella

PRINTED BY: HUGHESH1
DATE 5/8/2014

BILLING #: 001409700409
DICTATING PHYSICIAN: Brett C. Burgess, M.D.
CO-SIGNING PHYSICIAN:
ROOM AND BED: CV01AEMR
DATE OF BIRTH: 10/30/1981

University Medical Center
Savannah, Georgia

DEATH SUMMARY

placement as a last-ditch effort. He recommended ECMO. We took him immediately to the cardiac cath lab where I helped guide right atrial placement of a cannula via transesophageal echocardiography. He placed the cannulas in the left groin and patient was successfully placed on ECMO. We saw fairly dramatic improvement in his hemodynamic status. He was then moved to cardiovascular intensive care unit on ECMO with 24-hour perfusionist. It was determined he had a significant right lower lobe consolidation and pneumonia. He was felt to be in septic and cardiogenic shock. ECMO was continued for approximately 1 week. He was slowly weaned off ECMO successfully and cannulas were removed. He maintained an adequate blood pressure and eventually, all the pressors were discontinued. He was left on dobutamine for a few extra days for improved inotropic support. Sedation was weaned and he was not responding appropriately neurologically. Neurology consult was obtained. An EEG showed apparently significant slowing. MRI of the brain was then obtained, which revealed bilateral anoxic injury without hemorrhagic transformation or mass effect. His neurologic prognosis was felt to be extremely poor per Neurology. He was receiving broad-spectrum antibiotics throughout his hospital course. Ethics committee met regarding his case and felt at this point it was a futile care. Family meeting with Dr. Morris and the patient's mother and father. They agreed that they wanted to withdraw support. Patient was subsequently extubated and expired later that evening.

Brett C. Burgess, M.D.

BCB/MODL
D: 04/25/2014 6:20 P
T: 04/26/2014 5:27 A
Job #795974/Document #608535334
cc: Brett C. Burgess, M.D.

Authenticated by Brett C. Burgess, M.D. On 05/01/2014 10:25:31 AM

PRINTED BY: HUGHESH1
DATE 5/8/2014

LOFLN-3

JS 44 (Rev. 12/12)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS
BELINDA LEE MALEY, individually,
and on behalf of the ESTATE of
MATTHEW CLINTON MR. LOFLIN,

(b) County of Residence of First Listed Plaintiff Liberty County, Georgia
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
William R. Claiborne, Cameron C. Kuhlman, The Claiborne Firm, P.C.
410 E Bay Street, Savannah, GA 31401; S. Wesley Woolf, S. Wesley
Woolf, P.C. 408 E Bay Street, Savannah, GA 31401

DEFENDANTS
CORIZON HEALTH, INC.; CORIZON, LLC.; CHATHAM COUNTY;
ROY HARRIS; Estate of AL ST. LAWRENCE; JOHN WILCHER; Scott
H. KENNEDY, M.D.; ADAMAR GONZALEZ, M.D.; VIRGINIA O'NEILL

County of Residence of First Listed Defendant
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

CV 416-060

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated or Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated and Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

CONTRACT	TORTS		FORFEITURE/PENALTY	BANKRUPTCY	OTHER STATUTES
☐ 110 Insurance	PERSONAL INJURY	PERSONAL INJURY	☐ 625 Drug Related Seizure of Property 21 USC 881	☐ 422 Appeal 28 USC 158	☐ 375 False Claims Act
☐ 120 Marine	☐ 310 Airplane	☐ 365 Personal Injury - Product Liability	☐ 690 Other	☐ 423 Withdrawal 28 USC 157	☐ 400 State Reapportionment
☐ 130 Miller Act	☐ 315 Airplane Product Liability	☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability		PROPERTY RIGHTS	☐ 410 Antitrust
☐ 140 Negotiable Instrument	☐ 320 Assault, Libel & Slander	☐ 368 Asbestos Personal Injury Product Liability		☐ 820 Copyrights	☐ 430 Banks and Banking
☐ 150 Recovery of Overpayment & Enforcement of Judgment	☐ 330 Federal Employers' Liability	PERSONAL PROPERTY		☐ 830 Patent	☐ 450 Commerce
☐ 151 Medicare Act	☐ 340 Marine	☐ 370 Other Fraud	LABOR	☐ 840 Trademark	☐ 460 Deportation
☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)	☐ 345 Marine Product Liability	☐ 371 Truth in Lending	☐ 710 Fair Labor Standards Act	SOCIAL SECURITY	☐ 470 Racketeer Influenced and Corrupt Organizations
☐ 153 Recovery of Overpayment of Veteran's Benefits	☐ 350 Motor Vehicle	☐ 380 Other Personal Property Damage	☐ 720 Labor/Management Relations	☐ 861 HIA (1395ff)	☐ 480 Consumer Credit
☐ 160 Stockholders' Suits	☐ 355 Motor Vehicle Product Liability	☐ 385 Property Damage Product Liability	☐ 740 Railway Labor Act	☐ 862 Black Lung (923)	☐ 490 Cable/Sat TV
☐ 190 Other Contract	☐ 360 Other Personal Injury		☐ 751 Family and Medical Leave Act	☐ 863 DIWC/DIWW (405(g))	☐ 850 Securities/Commodities/ Exchange
☐ 195 Contract Product Liability	☐ 362 Personal Injury - Medical Malpractice		☐ 790 Other Labor Litigation	☐ 864 SSID Title XVI	☐ 890 Other Statutory Actions
☐ 196 Franchise			☐ 791 Employee Retirement Income Security Act	☐ 865 RSI (405(g))	☐ 891 Agricultural Acts
REAL PROPERTY	CIVIL RIGHTS	PRISONER PETITIONS	IMMIGRATION	FEDERAL TAX SUITS	☐ 893 Environmental Matters
☐ 210 Land Condemnation	☒ 440 Other Civil Rights	Habeas Corpus:	☐ 462 Naturalization Application	☐ 870 Taxes (U.S. Plaintiff or Defendant)	☐ 895 Freedom of Information Act
☐ 220 Foreclosure	☐ 441 Voting	☐ 463 Alien Detainee	☐ 465 Other Immigration Actions	☐ 871 IRS—Third Party 26 USC 7609	☐ 896 Arbitration
☐ 230 Rent Lease & Ejectment	☐ 442 Employment	☐ 510 Motions to Vacate Sentence			☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
☐ 240 Torts to Land	☐ 443 Housing/ Accommodations	☐ 530 General			☐ 950 Constitutionality of State Statutes
☐ 245 Tort Product Liability	☐ 445 Amer. w/Disabilities - Employment	☐ 535 Death Penalty			
☐ 290 All Other Real Property	☐ 446 Amer. w/Disabilities - Other	Other:			
	☐ 448 Education	☐ 540 Mandamus & Other			
		☐ 550 Civil Rights			
		☐ 555 Prison Condition			
		☐ 560 Civil Detainee - Conditions of Confinement			

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation

VI. CAUSE OF ACTION
Cite the U.S. Civil Statute under which you are filing *(Do not cite jurisdictional statutes unless diversity)*:
42 U.S.C. § 1983
Brief description of cause:
Violation of § 1983, deliberate indifference to serious medical needs; wrongful death

VII. REQUESTED IN COMPLAINT:
☐ CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P.
DEMAND $
CHECK YES only if demanded in complaint:
JURY DEMAND: ☐ Yes ☐ No

VIII. RELATED CASE(S) IF ANY *(See instructions)*:
JUDGE _____ DOCKET NUMBER _____

DATE
02/22/2016

SIGNATURE OF ATTORNEY OF RECORD
/s/ William R. Claiborne

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

Testimony of Andrea Armstrong
Law Visiting Committee Distinguished Professor of Law
Loyola University New Orleans, College of Law

Before the Permanent Subcommittee on Investigations of the
U.S. Senate Committee on Homeland Security and Governmental Affairs Committee

Hearing on
"Uncounted Deaths in America's Prisons and Jails: How the Department of justice Failed to Implement the Death in Custody Reporting Act"

Chairman Ossoff, Ranking Member Johnson, and Members of the Subcommittee:

Thank you for holding this hearing and for the opportunity to testify. My name is Andrea Armstrong. I am a law professor at Loyola University New Orleans, College of Law. I teach in the areas of criminal and constitutional law and research incarceration law and policy. I have visited prisons and jails across the country, including participating in audits of detention facility operations. My students and I created the Incarceration Transparency project and website, which collects, publishes and analyzes individual and facility-level records of deaths in custody in Louisiana prisons, jails, and detention centers. I also collaborate with researchers in eleven other states to collectively problem-solve data transparency issues for deaths in custody.

Introduction

Today, I focus my testimony on the critical importance of federal collection and publication of data on deaths in custody under the Death in Custody Reporting Act (DCRA) and the experiences of myself and my students in collecting this data in Louisiana for our Incarceration Transparency project. The work of your subcommittee is a vital part of our democratic tradition of transparency and accountability of public institutions. Through your efforts, we can ensure that our prisons, jails, and detention centers in the U.S. fulfill their constitutional obligations and perform as expected.

Just a few weeks ago, I received an email requesting assistance after he was told that the prison would not provide any specific information about the death of his "little brother."[1] He described his brother as a "pretty healthy young man" and wrote that "correctional facility is not telling us anything. They said that we needed a lawyer if we wanted more information."[2] Experiences like these decrease public trust in our criminal justice system and the ability of prisons to provide fair and appropriate punishment.

My testimony today is composed of three parts. First, I highlight our project's findings on deaths in custody in Louisiana and how we use federal death in custody data collection. Second, I explain why deaths in custody (and data collection) matter for public policy. Third, I identify significant problems with recent changes in the federal efforts to collect information about deaths

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[1] Confidential correspondence to Andrea Armstrong, on file with author (Aug. 20, 2022).
[2] *Id.*

in custody. Fourth, based on my research and the research of others around the country, I identify several tools to potentially improve transparency of deaths in custody with the aim of reducing preventable deaths in our nation's prisons, jails, and detention facilities.

I. Louisiana Deaths in Custody 2015-2019

In Louisiana, no one knew why and how people died behind bars in our state's prisons, jails, and detention centers prior . Louisiana leads the nation in incarceration.[3] We hold more people, per capita, than any other state in the South, easily outpacing our neighboring states. We are also increasingly holding people for other states and federal immigration authorities. At the same time, prisons, jails, and detention centers in Louisiana operate without independent oversight, mandatory standards, or public transparency.

Families, elected officials, and journalists lacked concrete information about deaths in custody. More often than not, they wanted to understand whether a recent death in custody was unique compared to other deaths and no one could answer their questions. National data from the U.S. Department of Justice's (DOJ) Bureau of Justice Statistics (BJS) wasn't helpful because BJS reports only report state outcomes, not facility outcomes.

Parish jails, which also house approximately 50% of our state prison population,[4] are only required to report deaths of people detained pending trial to their local coroner. Prisons, parish jails, and private prisons are only required to report deaths of people serving sentences to the Louisiana Department of Public Safety and Corrections (DPSC) headquarters and the local coroner. Some facilities, but not all, will issue individual press releases when a death behind bars occurs.[5] DPSC publishes limited and generalized data on causes of death for incarcerated people convicted of a crime in its quarterly Briefing Book. However, because DPSC does not provide demographic or facility information, it is impossible to identify broader patterns in deaths in custody.

A. Project Description and Findings

Since August 2019 law students at Loyola New Orleans have filed annual public records requests with 132 facilities, including all prisons, jails, juvenile detention centers (state and locally operated), and federal facilities. Students requested records of deaths in custody, including any records prepared and submitted to BJS or for deaths in 2020 to present, submitted to the Louisiana Commission on Law Enforcement (LCLE), the state coordinator for the Bureau of Justice

[3] Emily Widra & Tiana Herring, *States of Incarceration: The Global Context 2021*, PRISON POL'Y INITIATIVE (Sep. 2021), https://www.prisonpolicy.org/global/2021.html.
[4] Jails and private operators currently receive a per diem rate from the state of $26.39 per person, up from $24.39 during the project study period. Jails and private corporations received approximately $175 million in payments from the state in fiscal year 2019-2020. La. Dep't Pub. Safety & Corr., *Briefing Book*, 76 (July 2020).
[5] *See also* M. Forrest Behne et al., *When It Comes To Reporting Deaths of Incarcerated People, Most States Break the Law*, the Appeal (Mar. 2, 2022)(noting frequency of press releases does not match data reporting for certain states.)

Assistance (BJA).[6] Students also reviewed news and court litigation databases for their assigned parishes (counties) to identify unreported deaths occurring behind bars.

We found that at least 786 people died behind bars in Louisiana from 2015-2019. Black men ages 55-60 serving a sentence post-conviction are the largest impacted population by deaths behind bars, comprising 11% of all known deaths. Of the over 100 local jails in the state, East Baton Rouge Parish, Jefferson Parish, and Orleans Parish had the highest numbers of deaths. Fourteen percent of all known deaths behind bars were pre-trial, including two juveniles.

Our findings are based on responses from 69% of the facilities in the state. The remaining facilities did not respond to our repeated public records requests over two years, in violation of Louisiana Public Records Act § 44:1 et seq. The project has also not received any death data from federal agencies operating detention centers in Louisiana, which is particularly troubling as the number of people detained for immigration violations has soared since 2017.[7] In contrast, the state DPSC, which administers eight state prisons holding approximately 16,000 people, fully responded to our requests and also sent responses for people legally under their custody but serving their sentence in local jails.

Our first report, attached as Exhibit 1, provides the most comprehensive analysis of deaths behind bars in Louisiana to date. The full findings are detailed in the attached exhibit, however several are worth highlighting here:

1) **The majority (53%) of deaths due to medical illness were not from a pre-existing condition at time of admission.**

   Significance: Pre-existing condition data illustrates the importance of carceral health care. Prisons and jails are the exclusive source for diagnosing and treating diseases for the majority of medical-related deaths.

2) **Drug related deaths occurred long after admission to the facility, though a sizable number occurred within the first week for jails.**

   Significance: Drug related deaths occurring long past admission to the secure facility implicate the adequacy of facility security and contraband policies.

3) **Two-thirds of deaths due to violence occurred in cells, the majority of which involved assaults and blunt force trauma leading to head injuries.**

   Significance: This may indicate that the deadly violence was not a product of contraband or homemade weapons, but does implicate the adequacy of facility supervision and observation policies.

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[6] BJS Forms collected include CJ-9/CJ-9A (jails), NPS-4/NPS-4A (prisons), CJ-10/CJ-10A (private facilities) and NPS-5/NPS-5A (juveniles). Students also received correspondence from some facilities indicating there were zero deaths in that facility.

[7] *See* Laila Hlass & Mary Yanik, *No End in Sight: Prolonged and Punitive Detention of Immigrants in Louisiana*, 3, TUL. UNIV. IMMIGR. L. CLINIC (May 2021).

4) **Forty-three percent of all completed suicides in parish jails occurred in segregation cells compared to 7% in state prisons. Two out of three juvenile suicides occurred in segregation housing. Juvenile suicides occurred most often in the evenings.**

   Significance: Suicides in segregation are of particular concern, since segregation settings usually entail a higher level of individual supervision or observation than general shared cell or dorm settings. In addition, segregation cells are typically associated with more restrictive policies on items allowed in a segregation cell. The timing of the juvenile suicides may also point towards staffing and programming options in the evenings.

Our report, the full dataset, and a searchable database of all death records collected are all available online. Our choice to widely publish this data and our analysis was a deliberate effort to increase transparency of Louisiana's detention facilities. I have also shared our research and print copies of the report with community groups, the Louisiana Sheriff's Association and the Louisiana Department of Public Safety & Corrections, all of whom agreed the research was helpful for their efforts.

II. Deaths in Custody Matter

Every person who dies in a prison, jail, or detention center belongs to a family and community. Prison Policy Initiative, a non-partisan research organization, estimates that in 2021, 1.9 million people were behind bars in the United States.[8] How and why a person died in custody, however, is often kept secret, even from family members and relatives. As a result of my research, I am often contacted by family members seeking assistance in getting more information about the death of their loved one. For some families, our project is the first time they have seen official records on the death of their loved one. For example, a grieving family was told they would need to pay $500 in public records fees to obtain information about their cousin's apparent suicide in a local jail.[9] Unable to afford the fee, the family mourned while never understanding how and why he died. Seven years after his death in 2015, our project was able to obtain the records and worked with a family member to ensure they had support in place to revisit this traumatizing period of their lives.

Beyond the significant impact on families, this lack of transparency on deaths in custody undermines our nation's commitment to public safety. People, both free and incarcerated, are less likely to trust a system that hides vitally important information.[10] It is also impossible to fix what is invisible and hidden. As Justice Brandeis wrote, "[p]ublicity is justly commended as a remedy for social and industrial diseases. Sunlight is said to be the best of disinfectants; electric light the most efficient policeman."[11] Increasing public transparency on deaths in custody is critical step towards ultimately reducing deaths in custody.

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[8] Wendy Sawyer & Peter Wagner, *Mass Incarceration: The Whole Pie 2022*, PRISON POL'Y INITIATIVE (Mar. 14, 2022), https://www.prisonpolicy.org/reports/pie2022.html

[9] Confidential correspondence Andrea Armstrong, on file with author (Nov. 14, 2021, Nov. 30, 2021, Dec. 17, 2022, Feb. 3, 2022, Feb. 8, 2022, Mar. 7, 2022)

[10] *See* Jonathan Jackson et al., *Legitimacy and Procedural Justice in Prisons*, 191 PRISON SERVICE J. 4 (2010).

[11] Louis Brandeis, OTHER PEOPLE'S MONEY AND HOW BANKERS USE IT, 92 (1914).

Deaths in prisons, jails, and detention center are also important in light of these facilities' constitutional obligation to protect the health and safety of people in their custody.[12] This obligation includes preventing violence, providing emergency and regular medical and mental health care, and ensuring staff are properly trained to recognize and respond to life-threatening distress.

A. Deaths in custody should be rare events

Deaths in custody are an urgent matter of public concern. The overwhelming majority of people who die in custody have not been judicially sentenced to death. According to the BJS data from 2001 to 2018, 86,173 people died nationwide in jails and federal and state prisons.[13] Less than 1% of those deaths were judicially sentenced to death by a court as punishment for their crime.[14] While some medical-related deaths in prisons are to be expected due to life sentences, non-medical deaths in prisons and all deaths in jails and detention centers demonstrate that unexpected deaths behind bars also occur. Approximately 20% of deaths of people in jails and state and federal prisons nationally were of people detained pretrial from 2001-2018.[15] Given the presumption of innocence for people detained in jails, deaths of individuals pre-trial are particularly concerning.

Another reason that deaths behind bars should be rare is because incarcerated people do not (or should not) have access to illegal drugs and motor vehicles. For non-incarcerated people, poisoning (accidental overdoses) and motor vehicle accidents are two of the most prevalent accidental causes of death.[16] Accidental causes of death were the third highest cause of death for non-incarcerated people in 2019.[17] Carceral spaces, by definition, are highly controlled areas that regulate the movement and behavior of people within them.[18] For people who visit, work, or live in these secure facilities, entrance and exit from the facility is monitored and subject to search,

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[12] In general, the Due Process Clause of the Fourteenth Amendment governs conditions for people held pretrial (*Bell v. Wolfish*, 441 U.S. 520 (1979) (applying Fourteenth Amendment) and in a majority of circuits, to youth held in detention centers (Rudy Estrada & Jody Marksamer, *The Legal Rights of Young People in State Custody*, 5, 13 n. 28 (June 2006)), while the Eighth Amendment's prohibition of "cruel and unusual punishment" applies to people held pursuant to a conviction (*Estelle v. Gamble*, 429 U.S. 97 (1976) (applying Eighth Amendment).);

[13] National death data was compiled from the following three resources: E. Ann Carson, Bureau of Just. Stat., U.S. Dep't of Just., MORTALITY IN STATE AND FEDERAL PRISONS 2001-2018- STATISTICAL TABLES, 2 (2021) (reporting 67,874 deaths in federal and state prisons), [[hereinafter MORTALITY IN STATE AND FEDERAL PRISONS]; E. Ann Carson, Bureau of Just. Stat., U.S. Dep't of Just., MORTALITY IN LOCAL JAILS 2001-2018-STATISTICAL TABLES, 6 tbl.1 (2021), [hereinafter MORTALITY IN LOCAL JAILS 2001-2018] (reporting a total of 11,106 deaths from 2008–2018)).; Margaret Noonan, Bureau of Just. Stat., U.S. Dep't of Just., MORTALITY IN LOCAL JAILS 2000-2007, 7 tbl.8 (2010) (listing total number of deaths 2000–2007; for the years 2001–2007, 7,193 people died in custody in jails). Thus, the total number of deaths in jails 2001–2018 is 18,299.

[14] *See* Tracy Snell, Bureau of Just. Stat., U.S. Dep't of Just., CAPITAL PUNISHMENT 2020 – STATISTICAL TABLES, 18 (Dec. 2021).

[15] *See* note 13.

[16] Jiaquan Xu, Sherry L. Murphy, Kenneth D. Kochanek, & Elizabeth Arias, *Deaths: Final Data for 2019, 70 National Vital Statistics Reports* 1, 43 (July 26, 2021) (Table 7 indicating subcategories of accidental death).

[17] *Id.* at 1.

[18] *See* John J. Gibbons & Nicholas de B. Katzenbach, *Confronting Confinement: A Report of The Commission on Safety and Abuse in America's Prisons*, VERA INST. FOR JUST., 445 (June 2006).

limiting the introduction of contraband items inside the facility.[19] Similarly, as a deliberately contained population that does not have freedom of movement, incarcerated individuals are less likely to encounter the safety hazards of road travel..

Third, healthcare and other life-saving measures are potentially physically closer for emergencies than in the free world. Prison and jail administrators often point to the poor health of people admitted to their facilities as a contributing factor to deaths in custody. Available data does indicate a higher burden of significant medical conditions for incarcerated people, including chronic diseases like hypertension, diabetes, hepatitis, and asthma.[20] However, as discussed more fully in Part I, the majority of medical-related deaths in Louisiana were not from medical conditions diagnosed before entering the prison or jail. Instead, these conditions developed after admission to the facility. This data helps us understand the importance of providing constitutionally adequate health care, including timely diagnosis, treatment, and emergency care. Similarly, these facilities are staffed and operated 24 hours a day, 7 days a week. Thus, for medical emergencies or violent assaults, emergency or stabilizing assistance is usually physically closer for incarcerated people.

Deaths in custody can also be expensive for taxpayers, even with legal doctrines that limit recovery for wrongful deaths behind bars. Settlements and legal judgments for preventable deaths behind bars can cost millions of dollars, in addition to the significant expenditures to defend against these wrongful death cases. In one of the largest settlements for wrongful death behind bars in California, Alameda County and Corizon Health Inc, the private health care provider, agreed to pay 8.3 million dollars for the death of Martin Harrison.[21] Insurance premiums for facilities may also increase where there is evidence of prior wrongful deaths. A study of deaths in East Baton Rouge Parish Prison found that insurance premiums for that facility, in which 44 people died from 2012 to 2020, increased by 71% from 2011 to 2018.[22] Higher legal standards for proving wrongful death while incarcerated and the qualified immunity doctrine, which requires proof of violation of a clearly established constitutional or statutory right, limit recovery for families of decedents.[23] By limiting the financial costs of preventable deaths, these doctrines also limit the incentives for facilities to improve their policies and procedures to prevent future deaths.

Last, deaths in custody are significant because patterns in deaths behind bars may signal broader challenges in the prison, jail, or detention center. For example, if suicides tend to occur in certain jail cells, this could be an indication that those cells may be less observable from the guard station in a particular unit. In response, facilities could increase their required patrols in those areas or arrange for people on suicide watch to be housed closer to medical personnel.

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[19] *See Florence v. Bd. of Chosen Freeholders of Cty. of Burlington*, 566 U.S. 318, 326-329 (2012) (discussing rationale and case law on contact visits & searches of people admitted); *Walter Pavlo Corrections Officers Often Key to Contraband Introduced Into Prison*, FORBES (Sep. 30, 2021).

[20] Ingrid Binswanger et al. *Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population*, 63 J. OF EPIDEMIOLOGY & COMM. HEALTH. 912-19 (2009).

[21] Henry K. Lee, *$8.3 Million Settlement in Death of Alameda County Inmate*, SFGATE.COM (Feb. 10, 2015).

[22] Andrea Armstrong & Shanita Farris, *Dying in East Baton Rouge Parish Prison*, 22 (2018).

[23] For a more robust discussion of qualified immunity and higher standards of proof for wrongful death claims by family members of incarcerated decedents, *see* Andrea Armstrong, *Prison Medical Deaths and Qualified Immunity*, 112 J. CRIM. L. AND CRIMINOLOGY 79 (2021).

Similarly, if facility administrators see a pattern of heart disease deaths at younger than average ages, this may have implications for the food and exercise allowed for incarcerated people. The time of day for intentional incidents causing death, such as violence or suicide, may highlight a need for more robust programming or security during certain parts of the day to prevent future incidents.

B. Data collection is essential to fully understand the problem

Simply put, if we don't collect the data, we can't understand how and why people are dying while incarcerated. We also can't determine how many of the deaths are preventable. Homer Venters, a physician, epidemiologist and the former Chief Medical Officer of the NYC Correctional Health Services, has argued that a significant portion of deaths at Rikers Island jail were in fact preventable. Expert panels, including correctional administrators, have stressed the importance of accurate, more granular, and timely data for creating targeted interventions to reduce deaths. [24]

Chief medical examiners across the country have also emphasized the value of standardized reporting of deaths in custody. The National Association of Medical Examiners has issued a position paper proposing standard definitions, uniform investigation and autopsy practices, and statistical reporting.[25] Standardizing these practices, they argue, would increase "reliability and consistency" and "instill confidence in the medical examiner/forensic pathologist/coroner's independence by the criminal justice system, public health authorities, and the community at large."[26]

Facility-level data and detailed information about who dies in government custody is a difficult undertaking. Currently and historically, there is no single national source for data at the facility-level. While there is federal data collection under the Death in Custody Reporting Act, authorized by Congress, and analysis by state, these efforts have been dogged by non-compliance and vague definitions, providing only a broad overview of the causes of death. There are also challenges obtaining information when a state houses people from a different jurisdiction, but neither state reports the death. Recent changes internally by the DOJ on which bureau collects the data has also complicated data collection efforts.

III. Challenges in DCRA Reporting

A. DOJ-Bureau of Justice Statistics (BJS) Implementation

BJS has episodically published separate mortality reports for jails and prisons, with their latest reports for each (December 2021) analyzing data from 2000-2019. The data was collected via a

[24] *See* Joe Russo et al., Caring for Those in Custody: Identifying High-Priority Needs to Reduce Mortality in Correctional Facilities, 21-22, RAND Corporation (2017).
[25] Roger Mitchell, et. al., *National Association of Medical Examiners Position Paper: Recommendations for the Definition, Investigation, Postmortem Examination, and Reporting of Deaths in Custody*, 7 ACADEMY OF FORENSIC PATHOL. 604 18 (2017).
[26] *Id.* at 606.

standard survey and submitted by each state and local jurisdiction directly to the federal government. Officials completed the survey regardless of whether or not a death occurred.

The data released by BJS, however, does not provide for analysis by facility and state data is not disaggregated by race, age, or length of stay. Moreover, it is impossible to determine the completeness of the BJS data, particularly for jails, without a facility-level accounting of reporting institutions. Nevertheless, as the sole source of national and comparative data, the data collected by BJS through 2019 is critically important, and in our experience, superior to data subsequently collected through BJA.

B. DOJ-Bureau of Justice Assistance (BJA) Implementation

The transition of data collection to BJA has created significant difficulties on the ground for continued data collection.[27] As part of the transition, facilities were required to report deaths in custody to a central state office, which would collect the responses and submit them to federal authorities online. Facilities with zero deaths were not required to report, however, BJA could sanction jurisdictions that failed to report deaths in custody.

For 2020, the Louisiana Commission on Law Enforcement (LCLE), the central state agency responsible for BJA reporting, submitted a total of 6 deaths in custody for the state of Louisiana, the majority of which were from one parish.[28] In contrast, Loyola Law students, through public records requests and media searches, identified 180 deaths in Louisiana prisons and jails in 2020. Multiple sheriffs also informed our students that they were no longer required to report deaths in custody for federal data collection. (Exhibit 2).

If Louisiana's experience is similar to those of other states, 2020 will be the first year in two decades in which the federal government can not provide overall or comparative data on the causes of deaths in prisons, jails, and detention centers nationwide. In addition, it is unclear if BJA adopted any sanctions against Louisiana.

The gap in data during 2020 could not have occurred at a worse time. A report published by the Univ. of Texas-Austin found that state and particularly local facility reporting on Covid infections and reporting varied widely across the U.S., creating large gaps in data at a critical public health moment.[29] The authors concluded:

> This data gap means that policymakers, stakeholders, and the public do not know whether people in custody or the staff that work in these facilities are safe during this public health crisis; they cannot assess the

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[27] *See also* M. Forrest Behne et al., *supra* note 5 (reviewing state compliance with DCRA and making recommendations) .

[28] Correspondence with Bob Wertz, Law Enforcement Training Manager, Louisiana Commission on Law Enforcement (Apr. 12, 2022) with excel file attachment "Copy of Death-in-Custody-Reporting-Act-2022-04-12-Request" received via email pursuant to public records request with names redacted.

[29] Michele Deitch& William Bucknall, *Hidden Figures: Rating the Covid Data Transparency of Prisons, Jails, and Juvenile Agencies*, Covid, Corrections, & Oversight Project at Univ. of Tex.-Austin (Mar. 2021).

> risks to surrounding communities; and they do not know if correctional management approaches and policy responses are effective or equitable.[30]

Academic researchers have attempted to fill the gap in data, most notably for data around Covid-related deaths in prisons, jails, and detention centers. The UCLA Covid Behind Bars Data Project[31] began as a volunteer project to track mortality in all fifty states in real-time to support reforms that would reduce deaths in custody. It has since become an authoritative though unofficial and non-governmental source on deaths in custody.

For deaths occurring in 2021, LCLE reporting improved and included 191 deaths.[32] However, our initial review indicates our data collection provides significantly more detail on the circumstances of death than the data provided to BJA. For example, our records generally include the specific cause for medical deaths and the facility where the person was housed, even if he or she ultimately died in an external medical facility. In contrast, LCLE data provided to BJA only indicates if the death was due to "natural causes," without specifying the specific illness that caused the death. Thus, even with improved reporting, the Department of Justice will no longer be able to analyze medical causes of death and determine whether they are consistent with mortality causes in the general population.

C. Changes in death survey from BJS to BJA

To better understand the impact of moving death in custody data collection from BJS to BJA, I analyzed the survey instruments for both agencies. Some information will not be collected at all under BJA and even when it is collected, it provides less specificity than the BJS data collection. (A full comparison of the two data instruments is attached as Exhibit 3).

The following types of important information are no longer available under the BJA data series:

- **Facility population and admissions information**

This data is required to calculate mortality rates for local and state jurisdictions.

- **Facilities with zero deaths**

This data is important for prison and jail administrators to identify best practices, promote cross-facility learning, and replicate implementation.

- **Decedent specific data, including trial status, location of deaths and incidents leading to deaths, & pre-existing conditions, among others**

This data is essential for facilities to review their existing policies, procedures and operations to identify areas for improvement, including in security, medical, facility layout, and housing assignments. Trial status will be significant for those states, like Louisiana, that also house people convicted of state offenses in local jails.

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[30] *Id.* at 5.
[31] https://uclacovidbehindbars.org; *see also* Brendan Saloner et al., *Research letter: COVID-19 Cases and Deaths in Federal and State Prisons*, JAMA (2020)(relying data from the UCLA Covid Behind Bars Project)..
[32] *Id.*

- **Specific illnesses for medical-related causes of death.**

This data is critical for understanding the healthcare challenges for prisons, jails, and detention centers, as well as for statistical comparisons to causes of death for non-incarcerated populations.

IV. Tools to Reduce Deaths in Custody through Transparency

The lack of data on deaths in custody deprives taxpayers of critical information to understand the operations of their prisons, jails, and detention centers. It also undermines public trust in government agencies, while also depriving agency leaders of information needed to reduce deaths in their custody. Congress has a range of tools to address the current lack of transparency (including robust reporting and data collection) on deaths in custody, including:

A. DCRA 2013

DCRA 2013 could be amended to require data collection on all elements previously collected by BJS, including but not limited to restoring population/admissions, trial status, date of birth/age, housing status, specific medical illness, pre-existing conditions, & location of incidents/death categories. An amended DCRA could also require submission from all jurisdictions, regardless of whether or not a death occurred and that all jurisdictions with deaths identify whether or not the death is attributable to the jail. In addition, an amended DCRA could clarify reporting obligations between jurisdictions, where a state houses a person on behalf of another state. There is also an opportunity to improve upon the prior data collection efforts under BJS, by requiring publication of facility level data. Adopting these amendments would improve our understanding of current deaths in custody, including potential disparities. It would also allow for analytical comparisons to the almost 20 years of data previously collected.

B. Bi-partisan Congressional working committee

This bipartisan working committee could provide a key source of accountability for implementation of DCRA by monitoring state and DOJ compliance with DCRA. Members of the committee could review the quarterly reports of custodial deaths provided to the DOJ to evaluate state and BJA compliance with DCRA and make recommendations for sanctions for non-compliant jurisdictions. The committee could also make recommendations to improve state and DOJ compliance by assessing the adequacy of state submissions, identifying suitable sanctions for non-compliant facilities; and reviewing BJA outreach, education, and sanctioning efforts under DCRA.

C. Request to the U.S. Commission on Civil Rights

An increasing number of local and state jurisdictions in the U.S. have voluntarily adopted independent oversight to increase transparency and accountability, including death in custody reporting and review.[33] These oversight bodies collect data, report on, and monitor facilities for compliance with constitutional obligations. The U.S. Commission on Civil Rights (USCCR) is well-positioned to conduct a study of these bodies and make recommendations due to its long history of bipartisan fact finding, study, and recommendations regarding the administration and impact of criminal justice. State advisory committees to the USCCR have submitted reports that

[33] Michele Deitch, *But Who Oversees the Overseers?: The Status of Prison and Jail Oversight in the United States*, 47 AM. J. CRIM. L. 207, 210 (2020).

address prison conditions, incarceration rates, and solitary confinement. The USCCR has produced reports examining the civil rights protections for incarcerated women and the collateral consequences of incarceration.

D. Enact a new law to address legal barriers in litigation

Congress also has the power to shape incentives for detention facilities to reduce deaths in custody by eliminating the judicially-created "qualified immunity" defense for wrongful deaths in custody. Plaintiffs in these cases would still encounter higher standards of proof that are consistent with other types of claims for constitutional violations within detention facilities. Elimination of this doctrine would be a powerful signal that Congress has determined that a facility can not rely on the absence of specific factual predicates to avoid liability for certain deaths in custody.

E. Request to the CDC's National Center for Health Statistics

Congress can also work with the Center for Disease Control's National Center for Health Statistics to revise the U.S. Standard Death Certificate to include "in-custody" death option and study the feasibility of a U.S. Standard Custodial Death Certificate (similar to the certificates for Fetal Death). In addition, Congress could require the use of this certificate for jurisdictions participating in DCRA.

Conclusion

Deaths in custody should be rare events. Thus when they occur, it is critical that consistent and trustworthy data is available to understand how and why a person died. DCRA was amended to improve responsiveness and transparency of federal data collection efforts, but has had the opposite effect. Deaths in custody are now more invisible than before implementation of DCRA 2013. I urge this Subcommittee to treat these issues with the urgent attention they deserve. I and others stand ready to provide additional information or support as needed. Thank you for the invitation to share my perspective on these important issues.

EXHIBIT 1

LOUISIANA DEATHS BEHIND BARS 2015——2019

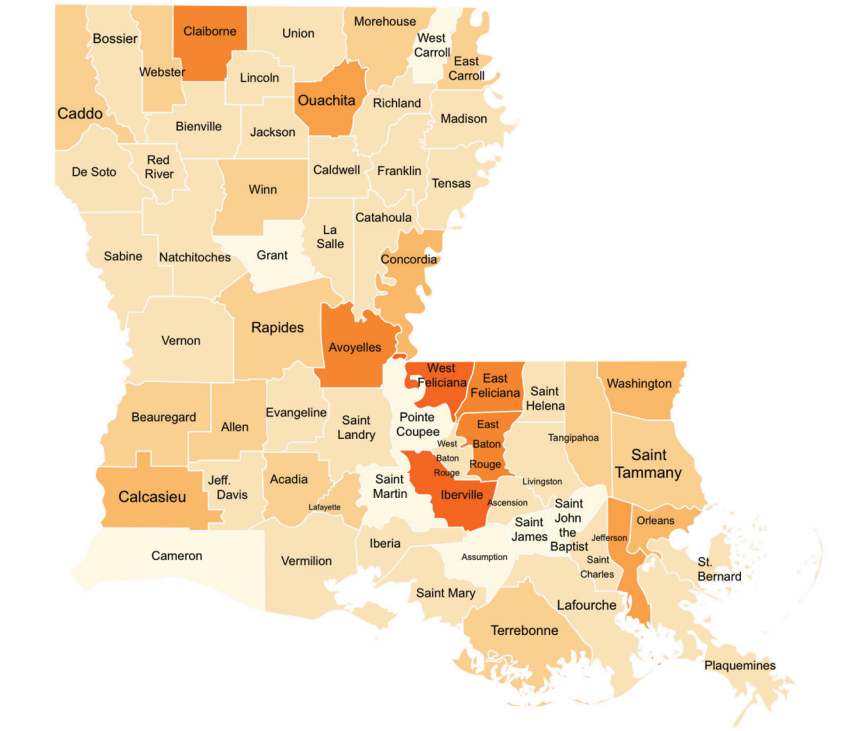
LOYOLA UNIVERSITY NEW ORLEANS COLLEGE OF LAW

Incarceration Transparency

JUNE 2021

CONTENTS

Heat Map of Known Deaths Behind Bars

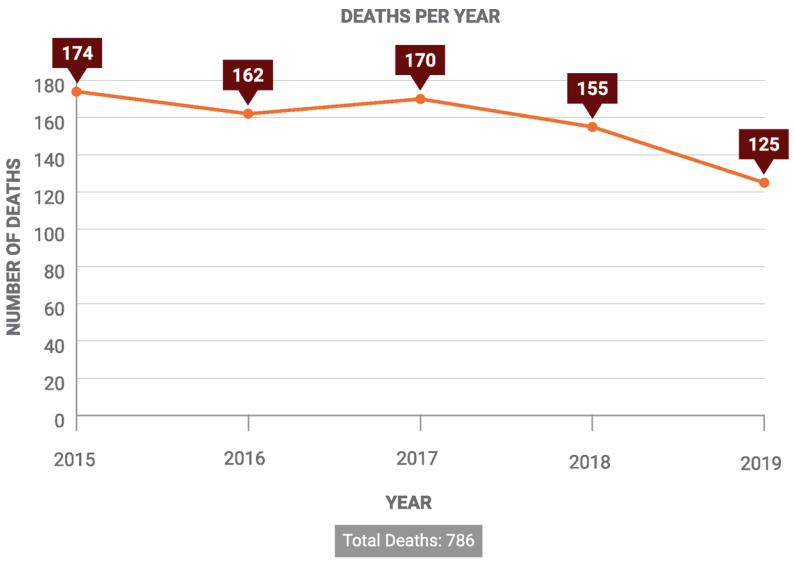


0 | 1-4 | 5-10 | 10-20 | 20-30 | 30-50 | 50+

2

INTRODUCTION

From 2015 to 2019, at least 786 incarcerated people died behind bars in prisons, jails, and detention centers across Louisiana. This report is the first comprehensive collection and analysis of deaths behind bars in Louisiana, based on public records requests filed with 132 facilities across the state.



Black men ages 55-60 serving a sentence post-conviction are the largest impacted population by deaths behind bars, comprising 11% of all known deaths. None of the 786 known deaths were judicially sentenced to death row. All were either detained before their trial, serving a judicially determined sentence for a set number of years or life, or were detained for a parole or probation violation. The overwhelming majority of people died of medical causes, with the highest rates for heart disease and cancer. Approximately half of known medical deaths were related to a pre-existing medical condition, indicating that half of medical related deaths were due to conditions first diagnosed by prison or jail medical staff. Though suicides were only approximately 6% of deaths, they were more likely to occur in parish jails and within those jails, half occurred in segregation, more commonly known as solitary confinement.

Louisiana leads the nation in incarceration. We hold the most people, per capita, than any other state in the South, easily outpacing our neighboring states. Our state and federal government are constitutionally obligated to provide safe and humane conditions for incarcerated people, including constitutionally adequate healthcare.[1] These obligations arise from the Fifth, Eighth, and Fourteenth Amendments to the U.S. Constitution and Article I §§ 2 and 20 of the Louisiana State Constitution.

[1] The U.S. Supreme Court has held that the U.S. Constitution requires the provision of medical and mental healthcare to incarcerated people consistent with the level of care provided in community. See e.g. *Estelle v. Gamble,* 429 U.S. 97 (1976); *Farmer v. Brennan,* 511 U.S. 825 (1994); *Brown v. Plata,* 563 US 493 (2011).

At the same time, prisons, jails, and detention centers in Louisiana operate without independent oversight, mandatory standards, or public transparency. Parish jails are only required to report deaths of people detained pending trial to their local coroner. Prisons, parish jails and private prisons are only required to report deaths of people serving sentences to the Louisiana Department of Public Safety and Corrections (DPSC) headquarters and the local coroner. Some facilities, but not all, will issue individual press releases when a death behind bars occurs. DPSC publishes limited and generalized data on causes of death for incarcerated people convicted of a crime in its quarterly Briefing Book, but does not provide demographic or facility information. Though most Louisiana facilities annually report deaths in custody to the federal Bureau of Justice Statistics within the U.S. Department of Justice, federal analysis based on these death in custody reports do not provide facility level information or disaggregate state data by race, age, or length of stay.

This project, through collecting and publishing data on deaths behind bars, aims to increase transparency of these public institutions and better understand how and why people die behind bars. Subsequent reports will compare the data collected on Louisiana deaths to national trends, as well as examine issues related to the data collection effort, including differential public records costs, facility and parish compliance, and the use of redactions by responding facilities.

Incarceration in Louisiana

Louisiana is relatively unique in the U.S. for using local jails to house approximately 50% of people serving their state sentence in a local jail. Jails are traditionally operated by local sheriffs and are primarily for people detained pretrial. They are designed for short-term housing and therefore often lack more robust services essential for people serving long-term sentences, including appropriate healthcare, recidivism prevention programming, and skills training. Prisons, on the other hand, are operated by the state and are primarily for people serving a judicially determined sentence after being convicted of a crime. As a result of this bifurcated system, the DPSC prioritizes state prison beds for people with longer sentences or serious health needs. Local jails and private operators, such as LaSalle Corrections, house the remaining state population of 50%, in addition to their traditional pretrial populations. Jails and private operators receive a per diem per person per day, which cost the state approximately $175 million for fiscal year 2019-2020.[2] The per diem rate paid by the state during the time period of this study - 2015 to 2019 - was $24.39.[3]

[2] La. Dep't Pub. Safety & Corr., Briefing Book, 76 (July 2020) at https://s32082.pcdn.co/wp-content/uploads/2020/08/Full-BB-Jul-20.pdf
[3] This rate was increased for fiscal year 2019-2020 to $25.39 and for fiscal year 2020-2021 and thereafter to $26.39. Act No. 245, La. Reg. Session (2019) (codified as amended at La. Rev. Stat. 15:824(B)(1)(a)).

Beyond jails and prisons, Louisiana also has a growing immigration detention population, housed in federally or privately operated prisons and parish jails through contracts with local sheriffs. After the legislature enacted significant reforms in 2017 pursuant to recommendations by the Louisiana Justice Reinvestment Initiative Taskforce, Louisiana anticipated a 10% reduction in population within 10 years. As those reforms have been implemented, jails and private facilities have turned to immigration detention to fill the recently emptied beds. There are also four "secure custody" juvenile detention centers operated by the state Office of Juvenile Justice, as well as thirteen locally operated "non-secure custody" juvenile detention centers.

Methodology

Loyola Law students filed public records requests with 132 facilities, including all prisons, jails, juvenile detention centers (state and locally operated), and federal facilities in Fall 2019 and 2020. Students requested records of deaths in custody, including any records prepared and submitted to the U.S. Department of Justice's Bureau of Justice Statistics (BJS).[4] BJS publishes separate mortality reports for jails and prisons, with their latest reports for each (April 2021) analyzing data from 2000-2018. The data released by BJS, however, does not provide for analysis by facility and state data is not disaggregated by race, age, or length of stay. Students also reviewed news and court litigation databases for their assigned parishes (counties) to identify unreported deaths occurring behind bars.

Of the 132 facilities included in this study, we received responses from 69% of facilities. Twenty-nine percent of facilities (38) did not respond to our repeated public records requests over two years, in violation of Louisiana Public Records Act § 44:1 *et seq*. The project has also not received any death data from federal agencies operating detention centers in Louisiana, which is particularly troubling as the number of people detained for immigration violations has soared since 2017.[5] In contrast, the state DPSC, which administers eight state prisons holding approximately 16,000 people, fully responded to our requests and also sent responses for people legally under their custody but serving their sentence in local jails.

All data utilized in this report, including documents actually received, is available for download and more refined analysis at www.incarcerationtransparency.org

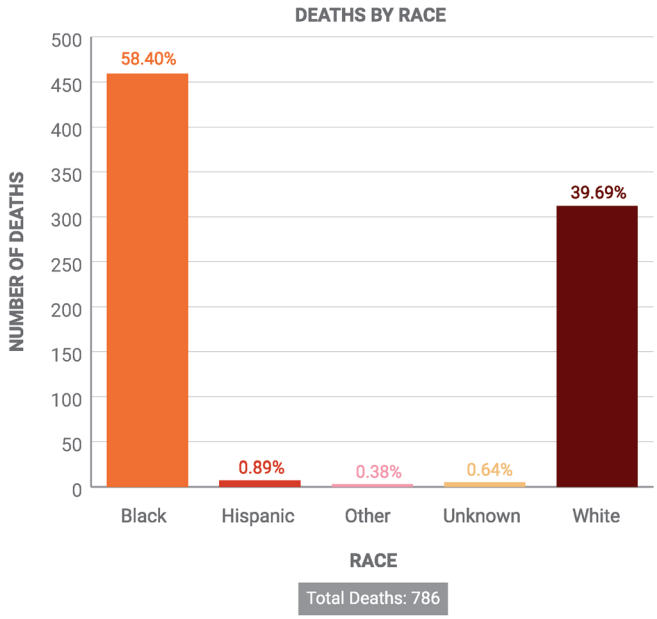
[4] Forms collected include CJ-9/CJ-9A (jails), NPS-4/NPS-4A (prisons), CJ-10/CJ-10A (private facilities) and NPS-5/NPS-5A (juveniles). Students also received correspondence from some facilities indicating there were zero deaths in that facility.

[5] *See* Laila Hlass & Mary Yanik, No End in Sight: Prolonged and Punitive Detention of Immigrants in Louisiana, 3, Tulane University Immigration Law Clinic at (May 2021) at https://law.tulane.edu/sites/law.tulane.edu/files/TLS%20No%20End%20In%20Sight%20Single%20Pages%20FINAL.pdf.

I. WHO IS DYING?

Race

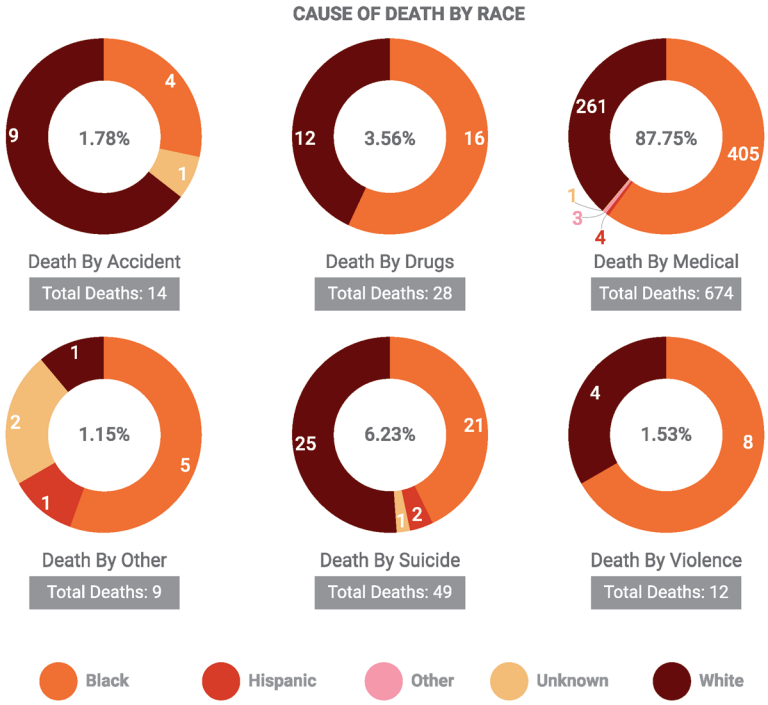
Deaths behind bars in Louisiana reflect our broader patterns of race in incarceration, with African-Americans overrepresented given their share of the state population. African-Americans are 67.5% of people committed to state custody after conviction, compared to Whites at 32.1% and "Other" at 0.4%.[6] In juvenile settings, African Americans are 81% of youth in secure custody and 75% in non-secure custody.[7] Demographic data by race is only available for people serving convictions (whether in prison or jail) and for youth in secure and non-secure care, but is not available overall for locally-operated jails.



[6] La. Dep't Pub. Safety & Corr., Briefing Book, 19 (July 2020) at https://s32082.pcdn.co/wp-content/uploads/2020/08/Full-BB-Jul-20.pdf
[7] Office of Juv. Justice, Fiscal Year 2017 Annual Report on Youth Served, 6 & 10 (2017) at https://ojj.la.gov/wp-content/uploads/2018/01/Act499TrendReportFY2017_-finalforwebsite-1.pdf

Of the 786 known deaths from 2015 to 2019, Black people were 58.40% (459) of deaths and White people were 39.69% (312) of deaths. Of the remaining 14 deaths, seven were listed as Hispanic and the remaining were either listed as “other” or “unknown.”

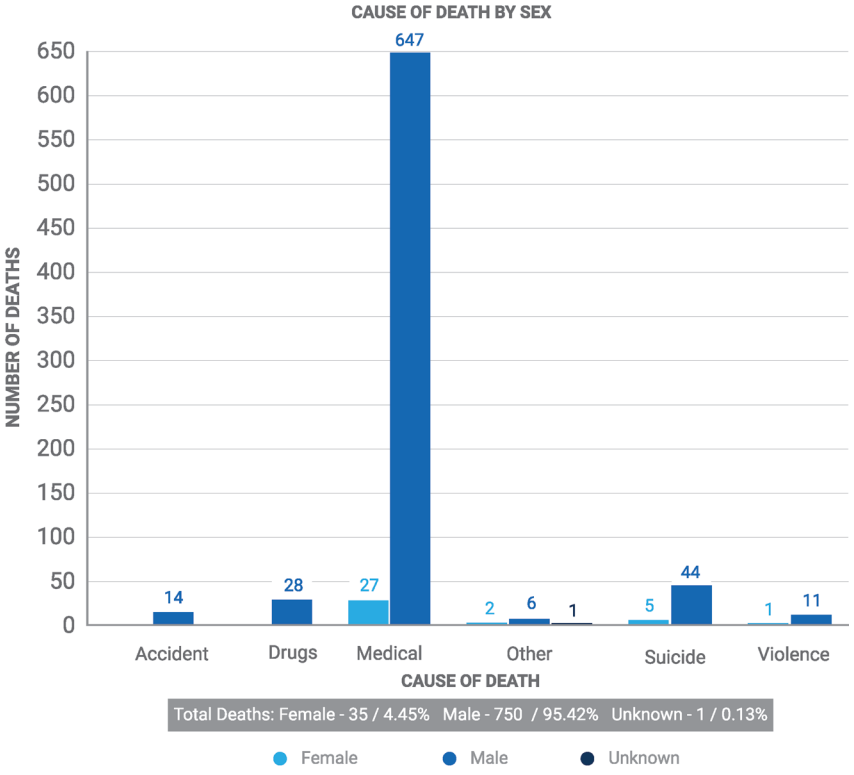
There appear to be differences among races depending on the cause of death. For medical causes of death, Black people are 60.9% of deaths, compared to White people at 38.72%. Violence, which only accounts for 1.53% of deaths, also shows a higher number of deaths for Black people behind bars (66.67%) versus White people behind bars (33.33%). Accidents, which generally are a small proportion of overall deaths, are the reverse, with Black people comprising 28.57% of accidental deaths, compared to White people at 64.29%.



Gender

Similar to race, known deaths by gender reflect broader incarceration patterns. Excluding people held pretrial or for immigration, adult men comprise 95.3% of people serving their sentence after conviction.[8] In juvenile settings, boys are 94% of youth held in secure custody and 84% of youth held in non-secure custody.[9]

Of the 786 death records reviewed, 95.42% were for men (750) versus 4.45% for women (35). Medical deaths were the leading cause of death for both men and women, followed by suicide. Deaths as a result of drugs or accidents were exclusively male.



[8] La. Dep't Pub. Safety & Corr., Briefing Book, 19 (July 2020) at https://s32082.pcdn.co/wp-content/uploads/2020/08/Full-BB-Jul-20.pdf
[9] Office of Juv. Justice, Fiscal Year 2017 Annual Report on Youth Served, 6 & 10 (2017) at https://ojj.la.gov/wp-content/uploads/2018/01/Act499TrendReportFY2017_-finalforwebsite-1.pdf

Age

Louisiana has one of the oldest prison populations in the nation due to mandatory minimum and multi-bill sentencing laws. Approximately 25% of people serving sentences in Louisiana are over 50 years old (up from 20% five years ago). The average age of people serving sentences post-conviction in Louisiana is 40 years old for men and women alike (up from 36 years old 5 years ago).

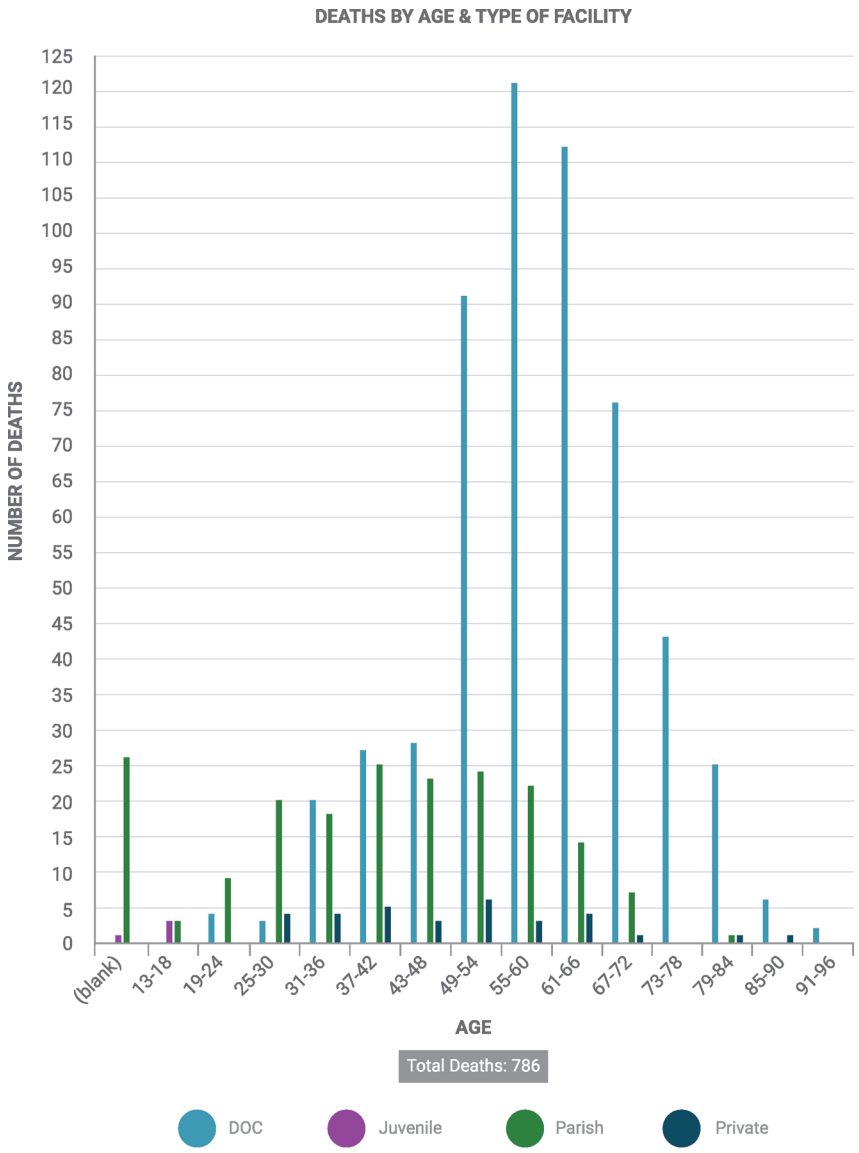
Known deaths behind bars in Louisiana range in age from 13-96 years old. Overall, people ages 55-60 years old make up 19.24% of deaths, with people ages 61-66 at 17.13% and 49-54 at 15.92%.

When we examine age of death by the type of facility, we see the same pattern for DPSC, with the highest percentage of deaths for people ages 55-60 (21.68%), followed closely by 61-66 years old (20.07%) and 49-54 (16.31%). Deaths in parish jails and private facilities skew younger. In parish jails, people ages 37-42 years old have the highest incidence of death (13.02%), followed closely by ages 49-54 (12.50%), then ages 43-48 (11.98%). In private facilities, people ages 49-54 (18.75%) have the highest incidence of death, then ages 37-42 (15.63%).

DEATHS BY AGE & TYPE OF FACILITY

	% Age				Total %
Age	DOC	Juvenile	Parish	Private	
(blank)	0.00%	25.00%	13.54%	0.00%	3.44%
13-18	0.00%	75.00%	1.56%	0.00%	0.76%
19-24	0.72%	0.00%	4.69%	0.00%	1.65%
25-30	0.54%	0.00%	10.42%	12.50%	3.44%
31-36	3.58%	0.00%	9.38%	12.50%	5.34%
37-42	4.84%	0.00%	13.02%	15.63%	7.25%
43-48	5.02%	0.00%	11.98%	9.38%	6.87%
49-54	16.31%	0.00%	12.50%	18.75%	15.39%
55-60	21.68%	0.00%	11.46%	9.38%	18.58%
61-66	20.07%	0.00%	7.29%	12.50%	16.54%
67-72	13.62%	0.00%	3.65%	3.13%	10.69%
73-78	7.71%	0.00%	0.00%	0.00%	5.47%
79-84	4.48%	0.00%	0.52%	3.13%	3.44%
85-90	1.08%	0.00%	0.00%	3.13%	0.89%
91-96	0.36%	0.00%	0.00%	0.00%	0.25%
Total	100.00%	100.00%	100.00%	100.00%	100.00%

Total Deaths: 786


DEATHS BY AGE & TYPE OF FACILITY
NUMBER OF DEATHS
125
120
115
110
105
100
95
90
85
80
75
70
65
60
55
50
45
40
35
30
25
20
15
10
5
0
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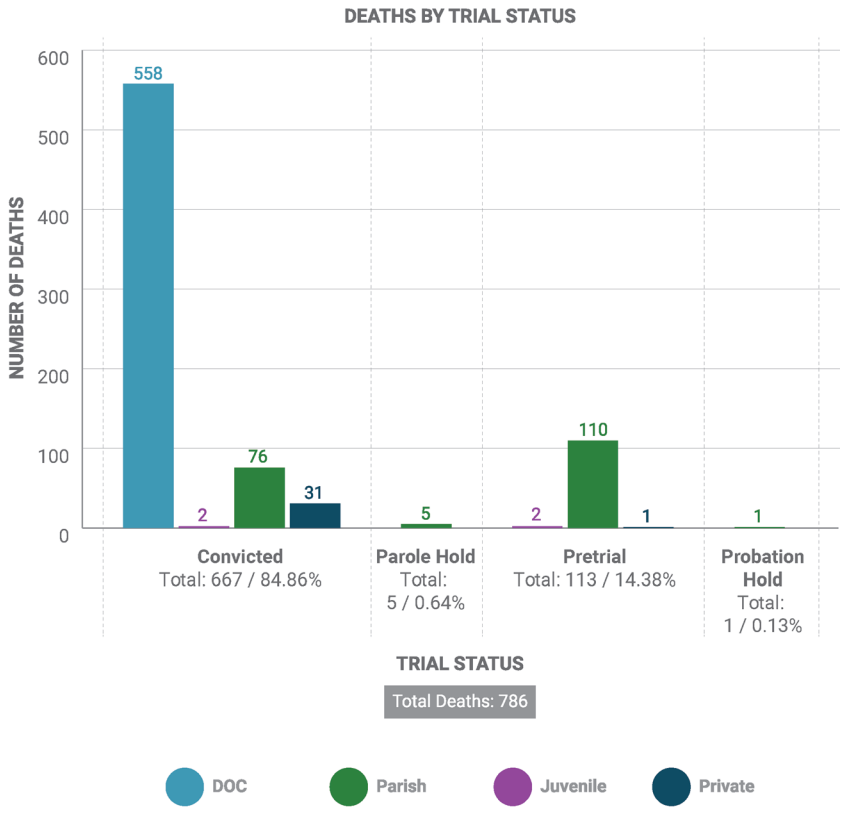
13-18
19-24
25-30
31-36
37-42
43-48
49-54
55-60
61-66
67-72
73-78
79-84
85-90
91-96
AGE
Total Deaths: 786
DOC
Juvenile
Parish
Private

11

Trial status

Approximately 85% of known deaths behind bars were of people serving a sentence for conviction of a crime. These deaths occurred primarily within DOC prisons (558 deaths for 70.99% of total deaths), but people with convictions also died serving their sentence in parish jails (76 for 9.67% of deaths), private facilities (31 deaths or 3.94%), and juvenile facilities (2 deaths). Pretrial deaths, i.e. deaths of people who had not yet had a trial determining their guilt or innocence, are 14.38% of all known deaths from 2015-2019, including two juveniles.

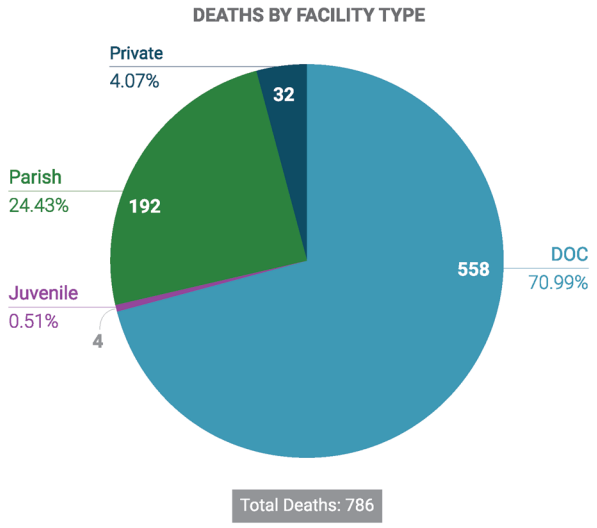


12

II. WHERE ARE THEY DYING?

Type of Facility

Louisiana has several different types of incarceration and detention settings, including state-operated prisons and youth detention centers, locally operated jails and youth detention centers, as well as privately managed jails and transitional work programs. Of the 786 known deaths, the majority occurred within state prisons, though deaths occurred in all types of facilities during the 2015-2019 period of review.



The number of total known deaths behind bars decreased in 2019, which could be a result of state reforms to reduce the incarcerated population statewide. In January 2015, 37,739 people were serving sentences post-conviction, including 18,767 housed in prisons, 18,027 housed in jails, and 945 housed in transitional work programs.[10] By December 2019, only

[10] La. Dep't Pub. Safety & Corr., Briefing Book, 13-14 (July 2020) at https://s32082.pcdn.co/wp-content/uploads/2020/08/Full-BB-Jul-20.pdf

31,609 people were serving state convictions, a reduction of over six thousand people. Of those 31,609 people, 15,042 served their sentence in a prison and 15,538 served their sentence in a local jail, with 1,029 people housed in a transitional work program.[11] The reduction of private deaths appears related to the operational transfer of Allen Correctional Center from a privately managed facility to a state-operated prison in 2017-2018.[12]

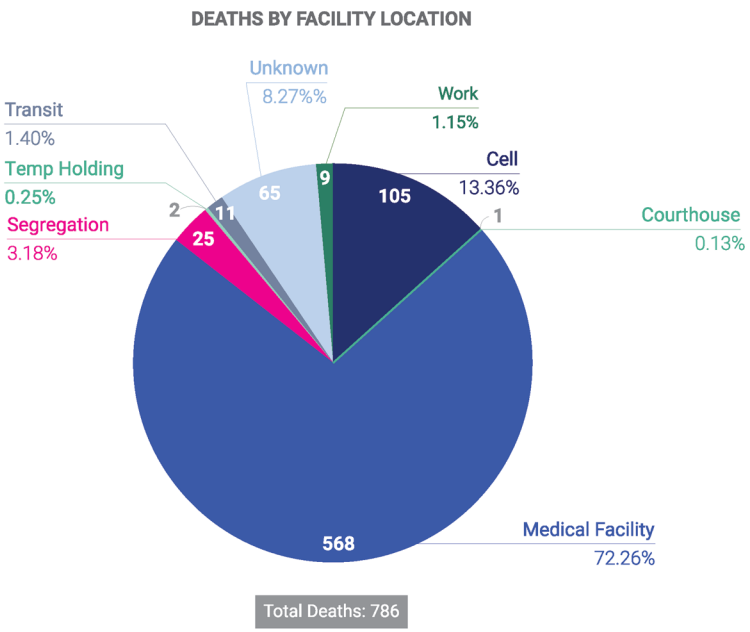
DEATHS BY YEAR & FACILITY TYPE

	DOC	Juvenile	Parish	Private	Total
2015	119		45	10	174
2016	116		34	12	162
2017	118	2	48	2	170
2018	110		39	6	155
2019	95	2	26	2	125
Total	**558**	**4**	**192**	**32**	**786**

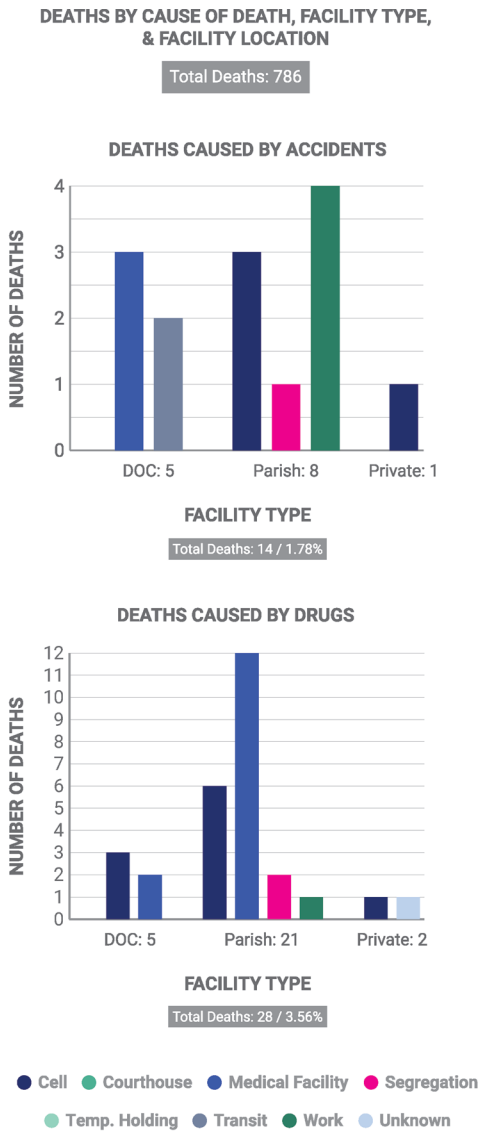
Location within facility

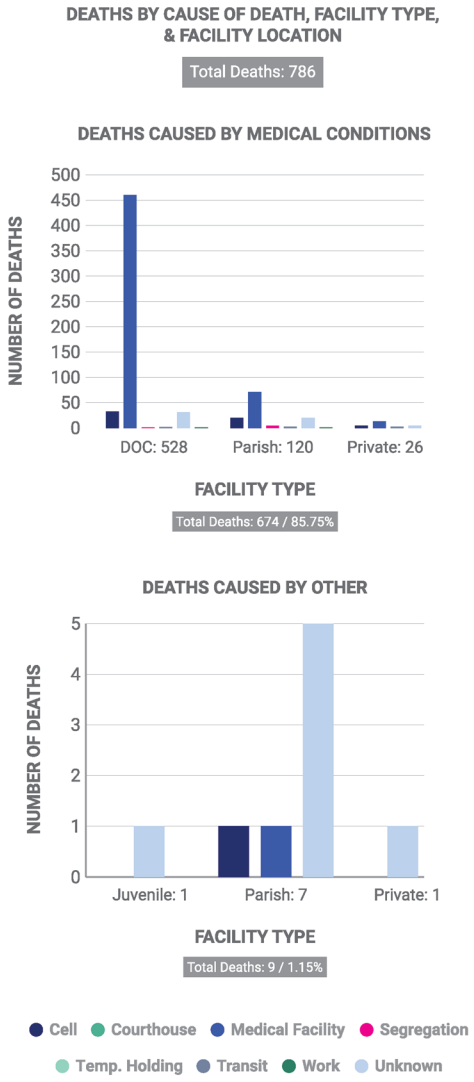
Almost three-quarters of deaths (72.6%) occurred in a medical facility, which is consistent with medical illness being the leading cause of known deaths. While the "unknown" death location appears large, a review of those records indicates the majority of those deaths occurred in medical facilities outside of the prison or jail. Deaths in segregation may indicate challenges for custodial supervision and/or reflect the unique isolation of segregation cells. Segregation, more commonly known as solitary confinement, is usually employed for discipline for rule violations, protective custody, or for close observation/suicide watch. In segregation, a person is typically allowed out of their 6x8 foot cell for 1-2 hours each day, but is otherwise isolated from human interaction, denied visitation or participation in programming, as well as other privileges.

[11] Id.
[12] Gordon Russel, Louisiana Department of Corrections to take over privately run Allen Correctional Center in Kinder, The Advocate (Aug. 16, 2017) at https://www.theadvocate.com/baton_rouge/news/article_b93d6ce4-8297-11e7-a5a8-afaf85c4af24.html

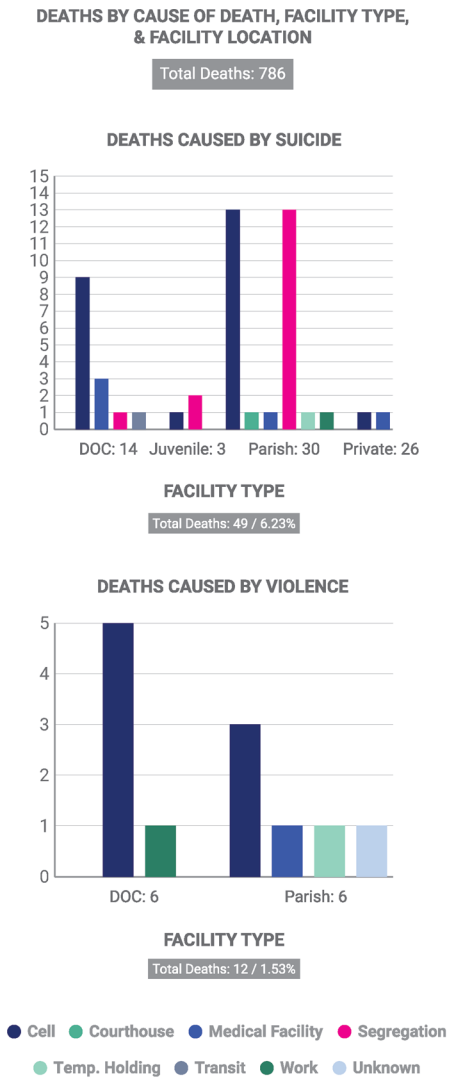


The following tables examine which types of deaths occur where within a facility and in which types of facilities. For example, though a relatively small proportion of overall known deaths, accidental deaths appear to be more common in parish jails than DPSC facilities and half of these parish accidental deaths are related to work injuries. Deaths due to drug overdoses also appear to be more common in parish jails than in prisons. Medical deaths are more likely to occur in non-medical spaces in parish jails (59.17%) than in state facilities (87.12%). This may be indicative of the fact that jails are generally less likely to have robust medical facilities behind bars, such as 24 hour infirmaries for patient treatment and observation. Suicides appear to be more typical in parish jails (30 deaths) than in state prisons (14 deaths).


DEATHS BY CAUSE OF DEATH, FACILITY TYPE, & FACILITY LOCATION
Total Deaths: 786
DEATHS CAUSED BY ACCIDENTS
NUMBER OF DEATHS
0
1
2
3
4
DOC: 5
Parish: 8
Private: 1
FACILITY TYPE
Total Deaths: 14 / 1.78%
DEATHS CAUSED BY DRUGS
NUMBER OF DEATHS
0
1
2
3
4
5
6
7
8
9
10
11
12
DOC: 5
Parish: 21
Private: 2
FACILITY TYPE
Total Deaths: 28 / 3.56%
Cell
Courthouse
Medical Facility
Segregation
Temp. Holding
Transit
Work
Unknown

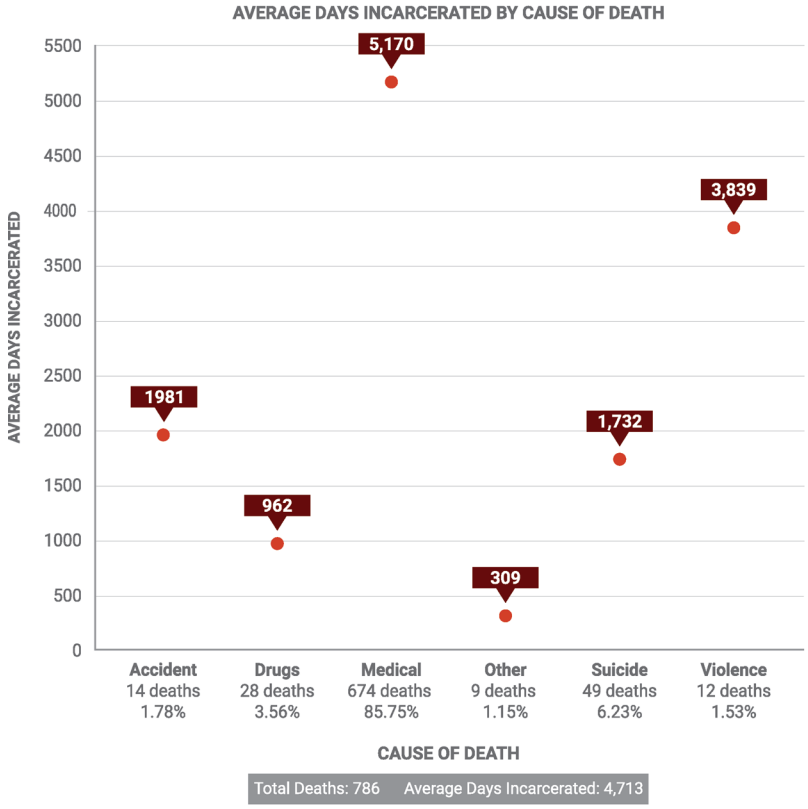

DEATHS BY CAUSE OF DEATH, FACILITY TYPE, & FACILITY LOCATION
Total Deaths: 786
DEATHS CAUSED BY MEDICAL CONDITIONS
NUMBER OF DEATHS
500
450
400
350
300
250
200
150
100
50
0
DOC: 528
Parish: 120
Private: 26
FACILITY TYPE
Total Deaths: 674 / 85.75%
DEATHS CAUSED BY OTHER
NUMBER OF DEATHS
5
4
3
2
1
0
Juvenile: 1
Parish: 7
Private: 1
FACILITY TYPE
Total Deaths: 9 / 1.15%
Cell
Courthouse
Medical Facility
Segregation
Temp. Holding
Transit
Work
Unknown

17


DEATHS BY CAUSE OF DEATH, FACILITY TYPE, & FACILITY LOCATION
Total Deaths: 786
DEATHS CAUSED BY SUICIDE
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1
0
DOC: 14
Juvenile: 3
Parish: 30
Private: 26
FACILITY TYPE
Total Deaths: 49 / 6.23%
DEATHS CAUSED BY VIOLENCE
5
4
3
2
1
0
DOC: 6
Parish: 6
FACILITY TYPE
Total Deaths: 12 / 1.53%
Cell
Courthouse
Medical Facility
Segregation
Temp. Holding
Transit
Work
Unknown

III. WHY ARE THEY DYING?

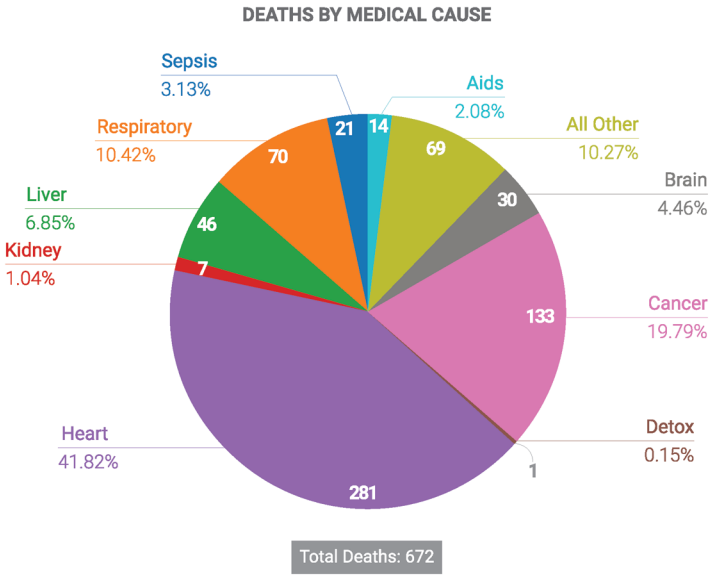
The vast majority of deaths (85.75%) were related to medical illness. Contrary to popular culture depictions of prisons and jails, known deaths due to violence are a relatively small overall proportion of deaths behind bars. The second leading cause of death at 6.23% are completed suicides. Drug overdoses are third at 3.56% and though a small overall proportion of deaths, these overdoses occurred close in time to admission but also after years of being incarcerated.



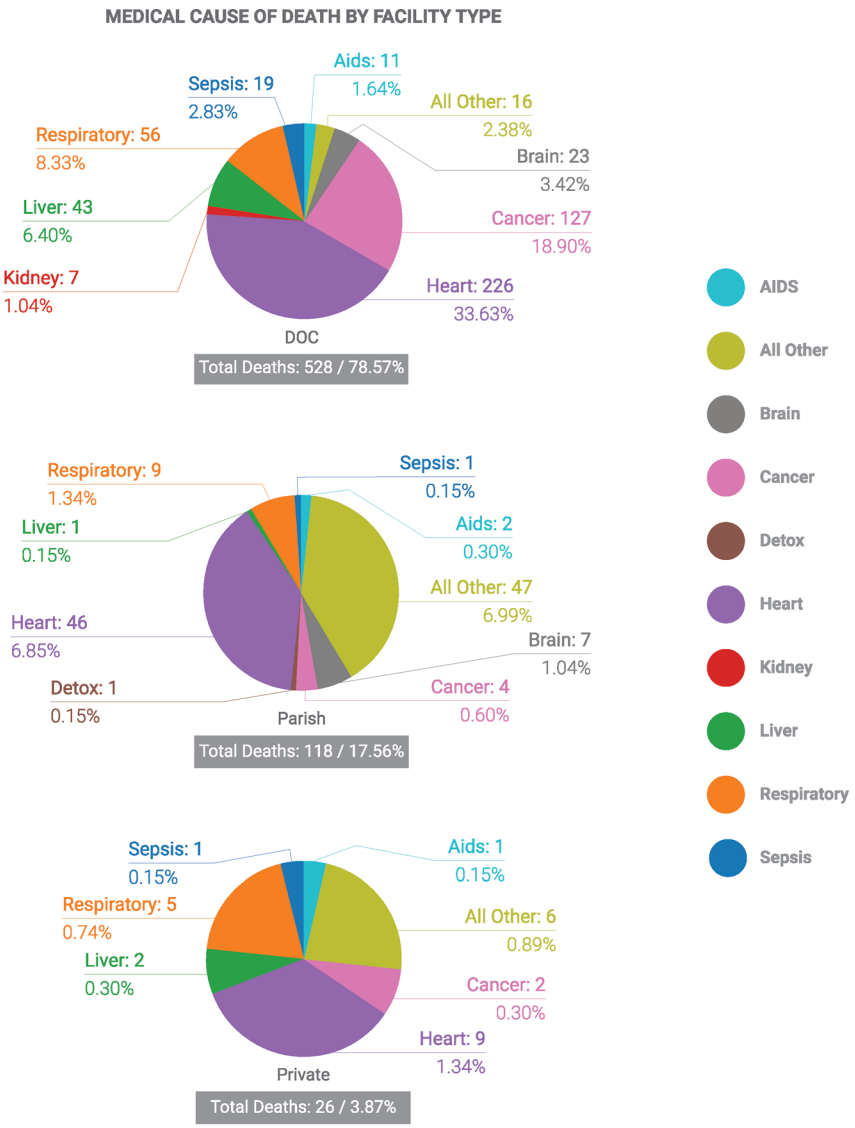
19

Medical Deaths

The leading causes of medically-related deaths behind bars are cancer and heart attacks. Approximately 10% of known deaths from 2015 to 2019 are due to respiratory illness. Some of the deaths within the "all other" category concern deaths at facilities that either redacted the medical cause of death, failed to provide descriptive details on the cause of death, or described the deaths as the result of "natural causes." Additional deaths within this category included deaths due to sickle cell, complications from hernia surgery, Alzheimers, and gastric ulcers, among others.



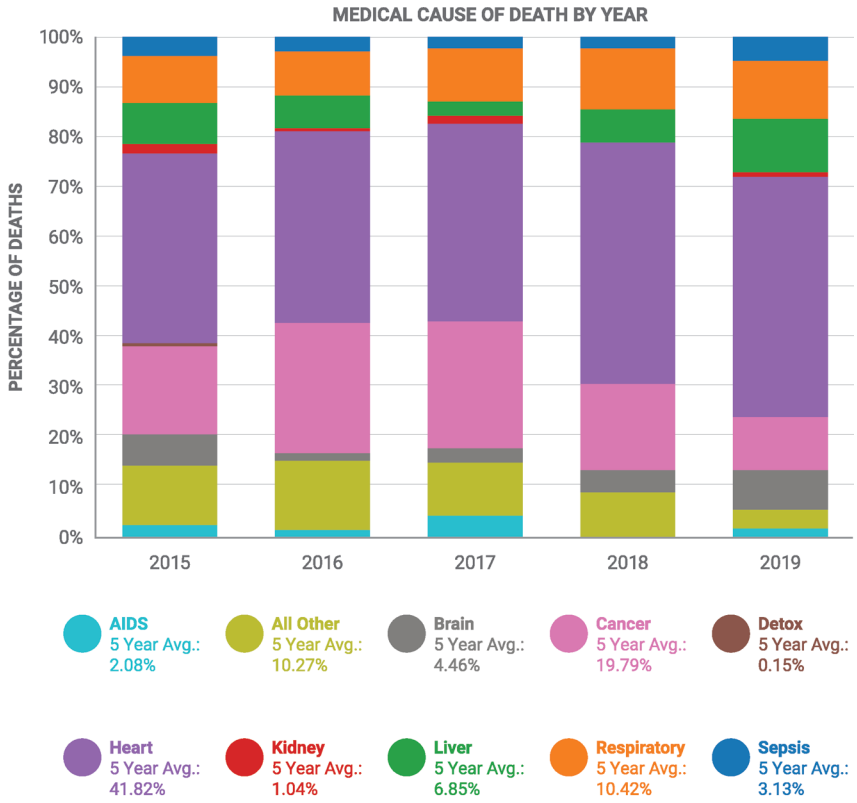
Of the known medical deaths, more than three-quarters occurred in state-operated prisons. For these prisons, heart disease and cancer were the leading causes of death. For parish jails and private facilities, the leading causes of death were heart disease as well as deaths by other causes (including deaths lacking more specific information).


MEDICAL CAUSE OF DEATH BY FACILITY TYPE
Aids: 11
1.64%
Sepsis: 19
2.83%
All Other: 16
2.38%
Respiratory: 56
8.33%
Brain: 23
3.42%
Liver: 43
6.40%
Cancer: 127
18.90%
Kidney: 7
1.04%
Heart: 226
33.63%
DOC
Total Deaths: 528 / 78.57%
Respiratory: 9
1.34%
Sepsis: 1
0.15%
Liver: 1
0.15%
Aids: 2
0.30%
All Other: 47
6.99%
Heart: 46
6.85%
Brain: 7
1.04%
Detox: 1
0.15%
Cancer: 4
0.60%
Parish
Total Deaths: 118 / 17.56%
Sepsis: 1
0.15%
Aids: 1
0.15%
Respiratory: 5
0.74%
All Other: 6
0.89%
Liver: 2
0.30%
Cancer: 2
0.30%
Heart: 9
1.34%
Private
Total Deaths: 26 / 3.87%
AIDS
All Other
Brain
Cancer
Detox
Heart
Kidney
Liver
Respiratory
Sepsis

Examining deaths by year indicates deaths due to complications from HIV/AIDS appear to be decreasing after a highpoint in 2017. The percentage of deaths from heart disease appears to be increasing from 2015 to 2019, while deaths from respiratory causes appear relatively steady throughout the reporting period.

MEDICAL CAUSE OF DEATH BY YEAR

Cause of Death	2015	2016	2017	2018	2019	Total
AIDS	2.52%	1.46%	4.32%	0.00%	1.92%	**2.08%**
All Other	11.95%	13.87%	10.79%	9.02%	3.85%	**10.27%**
Brain	6.29%	1.46%	2.88%	4.51%	7.69%	**4.46%**
Cancer	17.61%	26.28%	25.18%	17.29%	10.58%	**19.79%**
Detox	0.63%	0.00%	0.00%	0.00%	0.00%	**0.15%**
Heart	37.74%	37.96%	39.57%	48.12%	48.08%	**41.82%**
Kidney	1.89%	0.73%	1.44%	0.00%	0.96%	**1.04%**
Liver	8.18%	6.57%	2.88%	6.77%	10.58%	**6.85%**
Respiratory	9.43%	8.76%	10.79%	12.03%	11.54%	**10.42%**
Sepsis	3.77%	2.92%	2.16%	2.26%	4.81%	**3.13%**
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

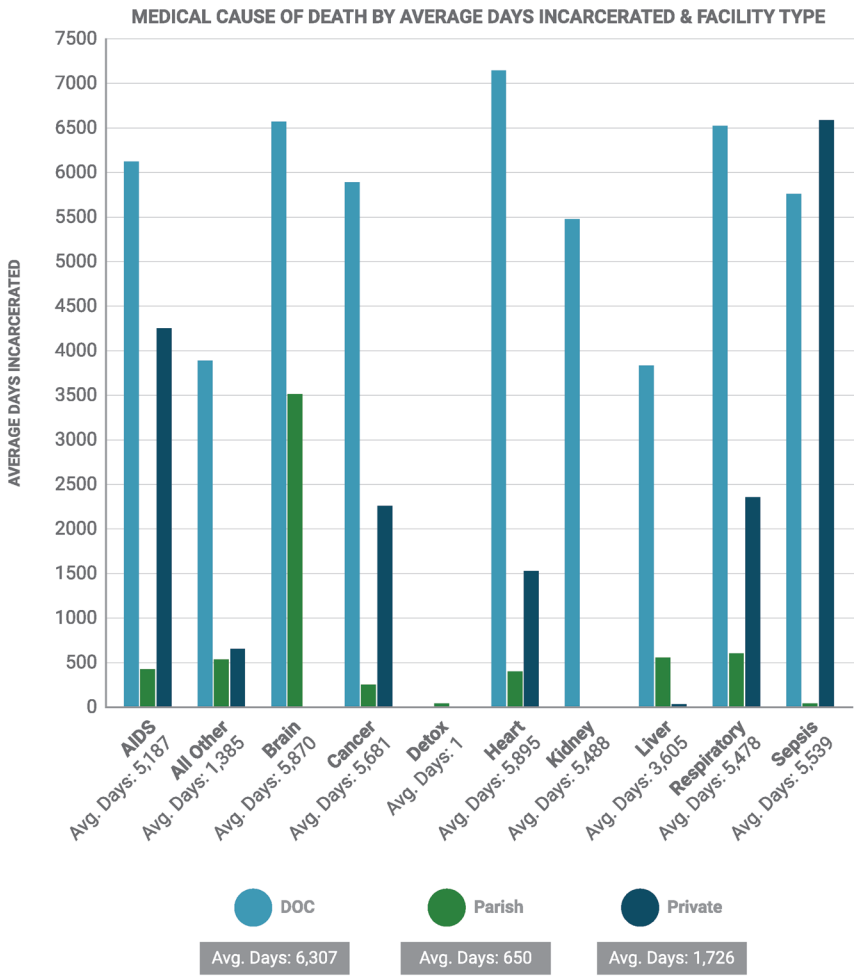


In general, the leading causes of medical-related deaths across race appear to be consistent, with heart disease and cancer the most common cause of death regardless of race. Black people, who are overrepresented behind bars, are also the clear majority of deaths for medical causes of death.

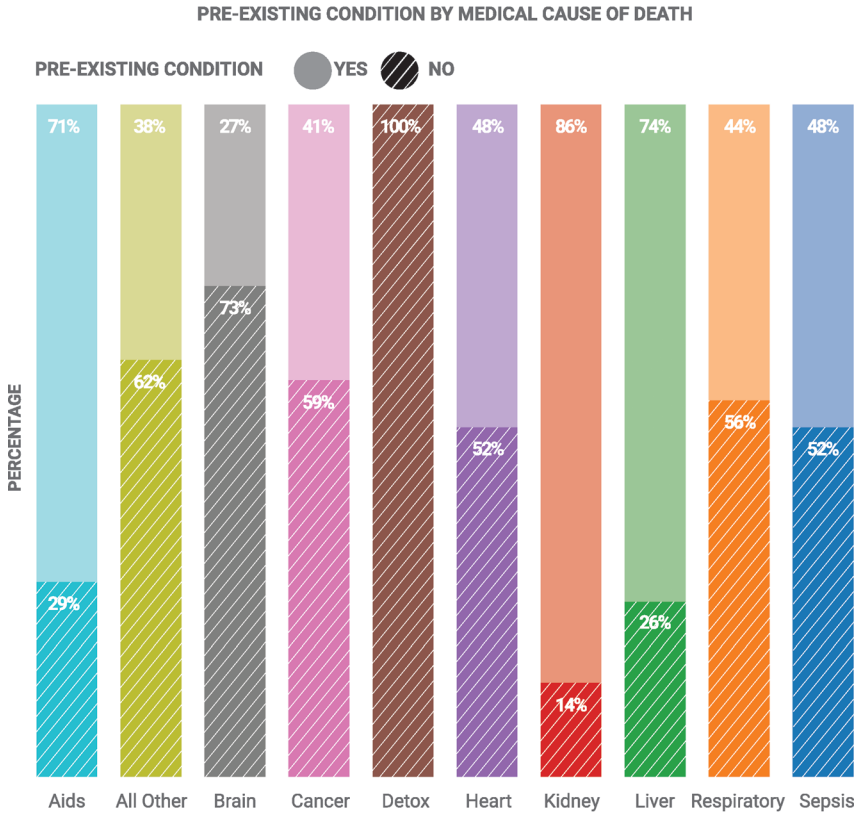
MEDICAL CAUSE OF DEATH BY RACE

Cause of Death	Black	Hispanic	Other	Unknown	White	Total
AIDS	1.19%	0.00%	0.00%	0.00%	0.89%	2.08%
All Other	5.95%	0.15%	0.15%	0.15%	3.87%	10.27%
Brain	2.53%	0.00%	0.00%	0.00%	1.93%	4.46%
Cancer	11.90%	0.15%	0.00%	0.00%	7.74%	19.79%
Detox	0.15%	0.00%	0.00%	0.00%	0.00%	0.15%
Heart	26.79%	0.30%	0.15%	0.00%	14.58%	41.82%
Kidney	0.74%	0.00%	0.00%	0.00%	0.30%	1.04%
Liver	3.42%	0.00%	0.15%	0.00%	3.27%	6.85%
Respiratory	5.95%	0.00%	0.00%	0.00%	4.46%	10.42%
Sepsis	1.34%	0.00%	0.00%	0.00%	1.79%	3.13%
Total	59.97%	0.60%	0.45%	0.15%	38.84%	100.00%

The average number of days incarcerated prior to medical death is highest for state prisons (approximately 17 years), compared to privately operated facilities (almost 5 years) and parish jails (1.7 years). In parish jails, deaths due to cancer on average occur within a year of incarceration and heart attack deaths within two years. Deaths due to sepsis, which is caused when a person's response to fighting infection damages internal tissues and organs, in one parish jail case occurred within two months of admission. All but one other sepsis death occurred in state prisons. Early intervention, through antibiotics, is critical as the incidence of death from sepsis increases quickly and sharply. In private facilities, of the two deaths due to liver disease, one occurred on the day of admission and the other 55 days after admission.


MEDICAL CAUSE OF DEATH BY AVERAGE DAYS INCARCERATED & FACILITY TYPE
AVERAGE DAYS INCARCERATED
7500
7000
6500
6000
5500
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
AIDS
Avg. Days: 5,187
All Other
Avg. Days: 1,385
Brain
Avg. Days: 5,870
Cancer
Avg. Days: 5,681
Detox
Avg. Days: 1
Heart
Avg. Days: 5,895
Kidney
Avg. Days: 5,488
Liver
Avg. Days: 3,605
Respiratory
Avg. Days: 5,478
Sepsis
Avg. Days: 5,539
DOC
Avg. Days: 6,307
Parish
Avg. Days: 650
Private
Avg. Days: 1,726

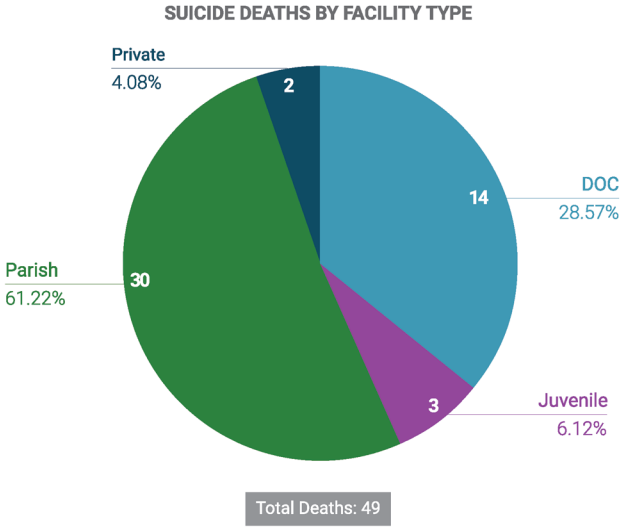
On average, less than half of known deaths were due to a medical condition that existed prior to detention behind bars, indicating that the medical condition in 53% of cases was initially diagnosed after being incarcerated. Only medical deaths due to three diseases (HIV/AIDS, liver, and kidney diseases) were more likely to be due to a pre-existing condition prior to incarceration. The development of - and death from - other diseases during incarceration is likely related to the length of sentences in Louisiana and may implicate the general lack of preventative health care for incarcerated adults under the age of 50 years old.[13]



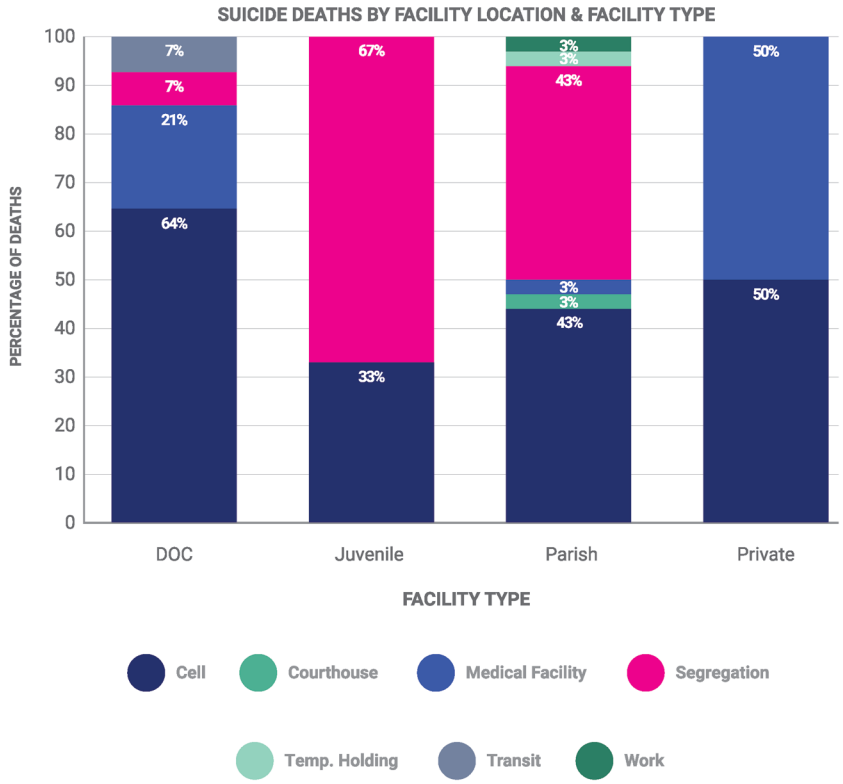
[13] For more discussion of preventative health care policies in state prisons in Louisiana, see Andrea Armstrong, Bruce Reilly, & Ashley Wennerstrom, Study Brief: Adequacy of Healthcare Provided in Louisiana State Prisons, 4-5 (May 2021) at https://www.loyno.edu/sites/default/files/2021-05/DPSC_Healthcare_Brief.pdf

Suicide

Contrary to the pattern of medical deaths occurring primarily in state prisons, completed suicides occurred more frequently in parish jails. Almost two-thirds of suicides occurred in parish jails. Suicide is also the leading cause of death for youth held in detention. Three of the four deaths in youth detention centers were due to suicide, with details on the cause of death for the fourth child unknown. The majority of suicide deaths at all facilities were completed by hanging, though records indicate one suicide by "single gun shot to the head" while at the parish courthouse and another involved a "self-inflict[ed] stab wound to the neck."



There are differences in where suicides are completed depending on the type of facility. Almost two-thirds of the completed and known suicides in state prisons occurred in a person's cell and only 7% occurred in segregation. In contrast, suicides in segregation were more common in youth detention centers and parish jails. Suicides in segregation are of particular concern, since segregation settings usually entail a higher level of individual supervision/ observation than general shared cell or dorm settings combined with more restrictive policies on items allowed in a segregation cell. Half of all completed suicides in parish jails occurred in segregation cells, raising questions about the degree of observation performed by custodial and medical staff. All but two of these segregation parish jail suicides were hangings.

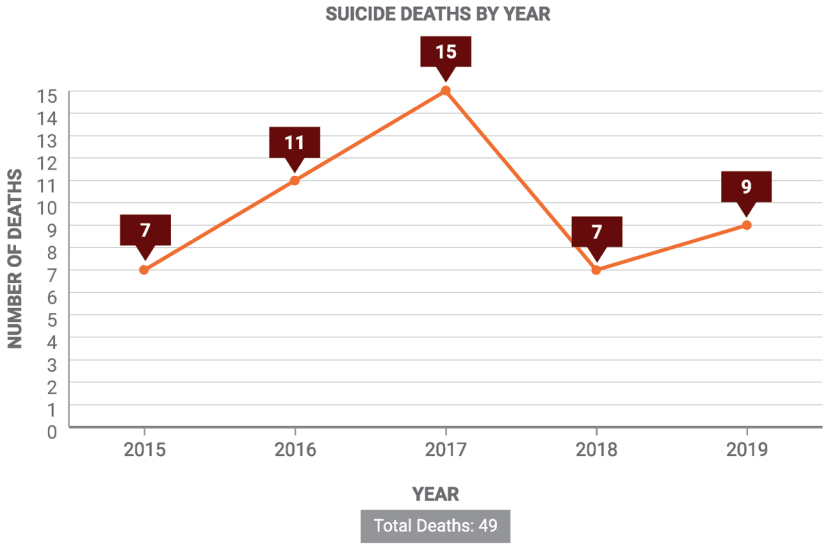


For youth deaths, two out of three suicides occurred during the evening hours, when there is less probability of educational or rehabilitative programming occuring. For state prisons, suicides were more likely to occur (or be discovered) between six o'clock in the morning and noon. In contrast, completed suicides occurred (or were discovered) pretty evenly throughout the day in parish jails, which raises questions about supervision/observation and perhaps the lack of other activities, such as programming or outdoor recreation, during the day.

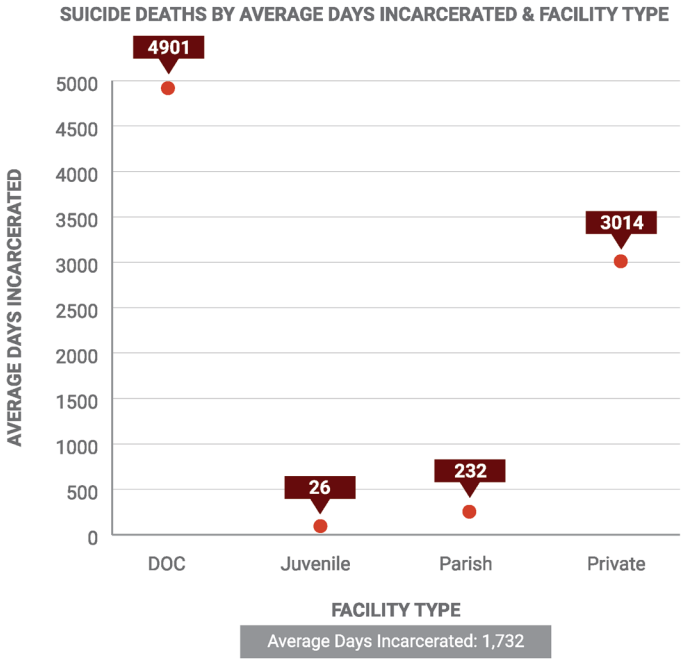
SUICIDE DEATHS BY TIME OF DAY & FACILITY TYPE

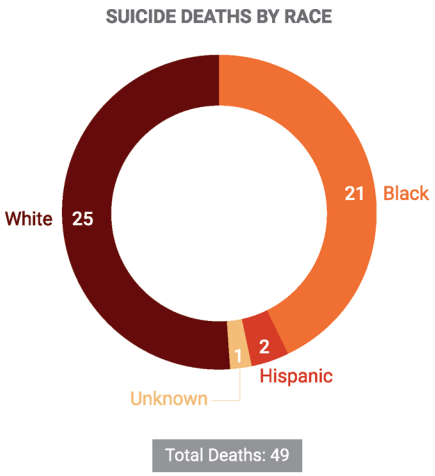
	DOC	Juvenile	Parish	Private	Total
Morning (6am to noon)	43%	0%	27%	0%	29%
Afternoon (noon to 6pm)	29%	0%	23%	50%	24%
Evening (6pm to midnight)	14%	67%	27%	0%	24%
Overnight (midnight to 6am)	14%	0%	17%	50%	16%
Unknown	0%	33%	7%	0%	6%
Total	100%	100%	100%	100%	100%

Known suicide deaths were highest in 2017, comprising 8.8% of deaths for that year. Though the number of known suicide deaths (9) was substantially less in 2019, completed suicides as a proportion of overall deaths for that year was higher (7%) than for other years including 2015 (4%) and 2018 (4.5%).



The average number of days incarcerated prior to death by suicide indicates that suicides occur relatively early in juvenile detention. One of the youth suicides happened within 9 days, the second at 43 days, while records for the third suicide did not indicate length of stay. The average length of incarceration for completed known suicides in parish jails ranged from the first day of incarceration to one year and eight months (684 days). The latter suicide concerned a person incarcerated pre-trial and occurred in segregation/solitary housing. Seven of the thirty suicide deaths in parish jails occurred within the first week of incarceration. Both privately operated and state prisons had on average, longer lengths of incarceration prior to suicide, ranging from 2 to 32 years prior to death.

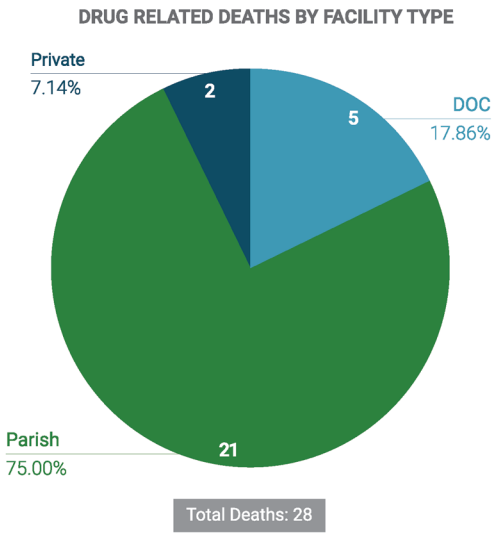




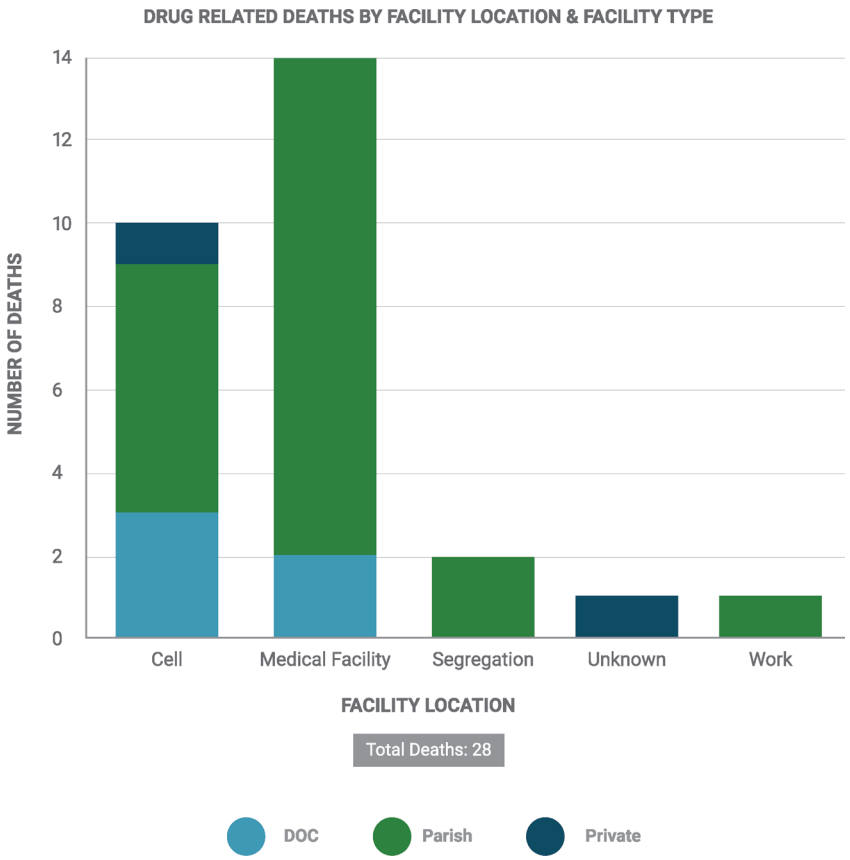
In contrast to most other causes of death, African-Americans are not a majority of suicide deaths. Black people are 43% of suicide deaths, compared to White people at 51%. Four of the five suicide deaths of women were White.

Drugs

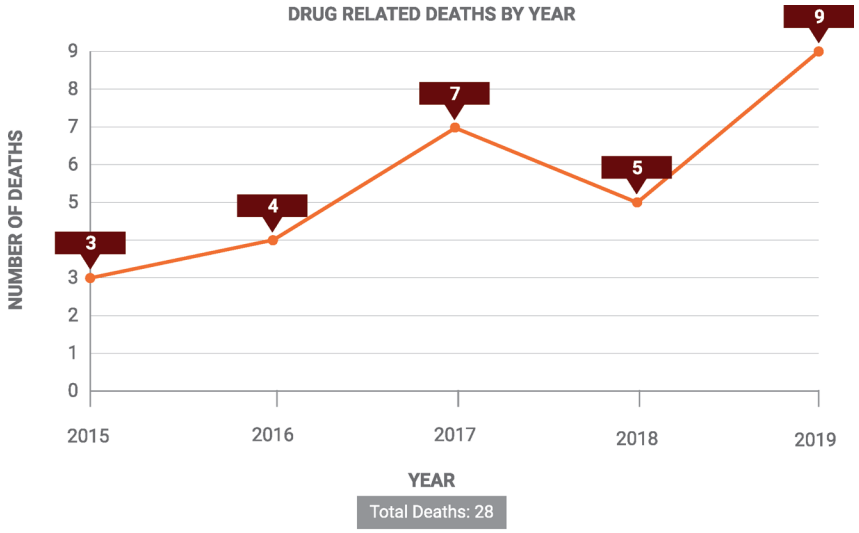
Drug overdoses are a relatively small proportion of overall deaths and similar to suicides, are more likely to occur in parish jails than other types of facilities. Drugs causing death included cocaine, heroin, methamphetamines, fentanyl, ibuprofen, synthetic cannabinoids, and inhaled hydrocarbons. Not all records specified the drug overdosed, however, where listed, methamphetamines, heroin, and fentanyl appeared most common.



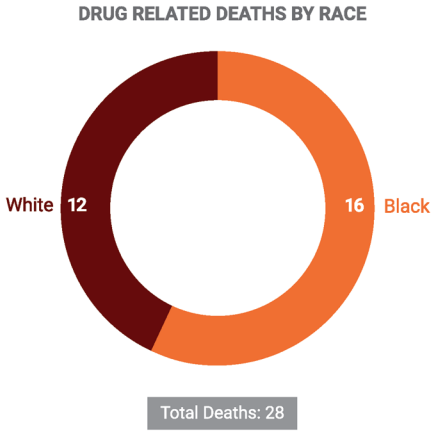
Approximately half of the deaths related to drug overdose occurred in medical facilities, though that is not necessarily the location for the ingestion of the drugs. The two drug-related deaths that occurred in segregation were relatively early admissions with one dying on the same day as admitted and the other after 11 days of incarceration.



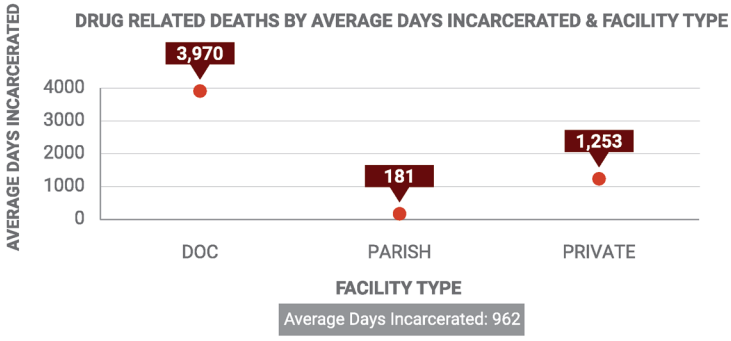
Known drug-related deaths appear to be increasing in number over time. The lowest proportion of drug-related deaths was in 2015 at 1.7% of overall known deaths behind bars. By 2019, drug-related deaths were 7% of overall deaths for the year.



All drug overdose deaths behind bars from 2015-2019 are male. Black males are the majority of these deaths (57%) consistent with their overrepresentation in the incarcerated population.

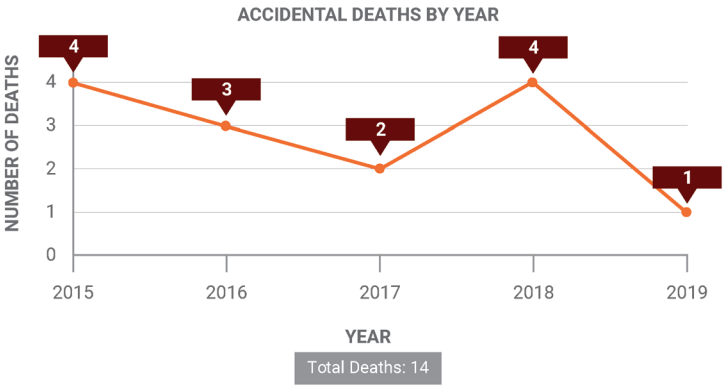


Drug overdoses occurring close to admission implicates policies on hospital transfers for medical distress. Drug overdoses occurring later in a person's incarceration implicate the ability of staff to limit the introduction of contraband behind bars. The average number of days incarcerated prior to a drug related death is lowest in jails at approximately 6 months, while the average for private facilities is approximately 3 years and almost 11 years for state prisons.

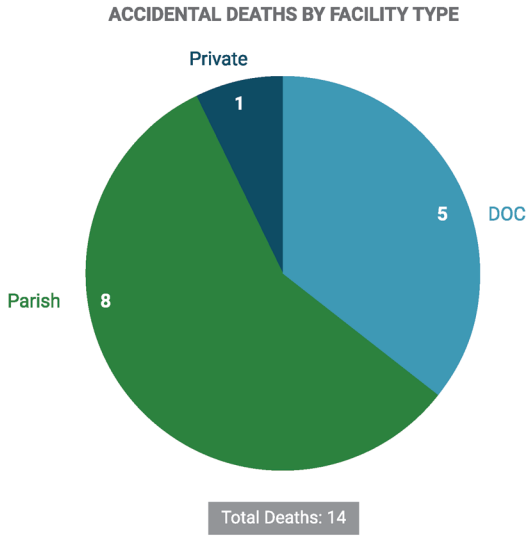


Accident

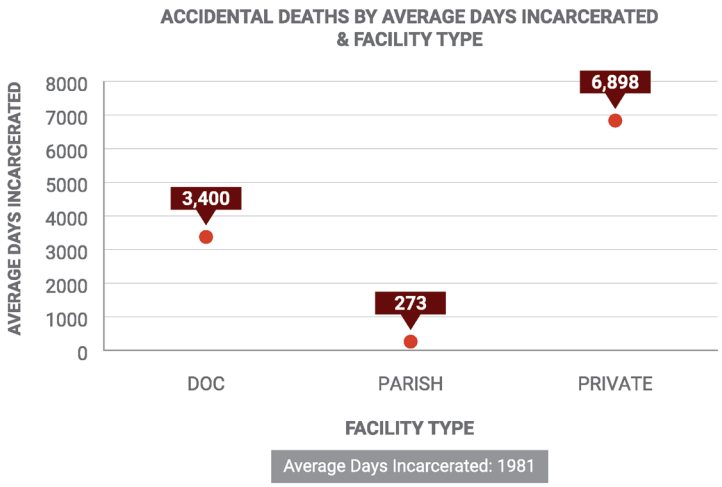
Deaths due to accidents behind bars primarily involved head injuries leading to traumatic brain injuries. One death is reported as "accidental" but concerns an officer-involved shooting after the person's apparent failure to heed the prior fired warning shot. Two of the accidental deaths involved drowning.



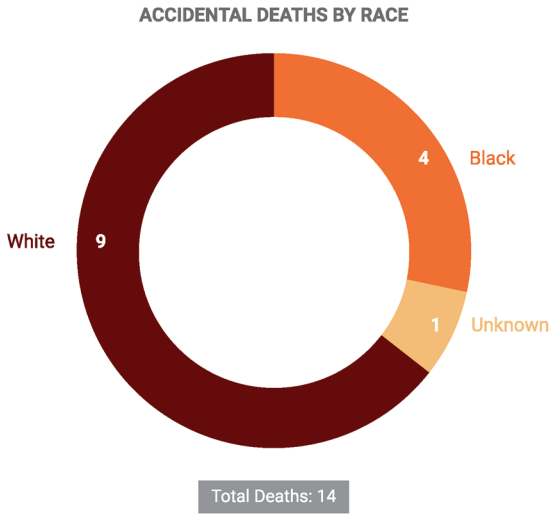
The majority of deaths due to accidents occurred in parish jails, compared to state or private facilities, though some of those in parish jails are related to work-related injuries sustained outside of the facility.



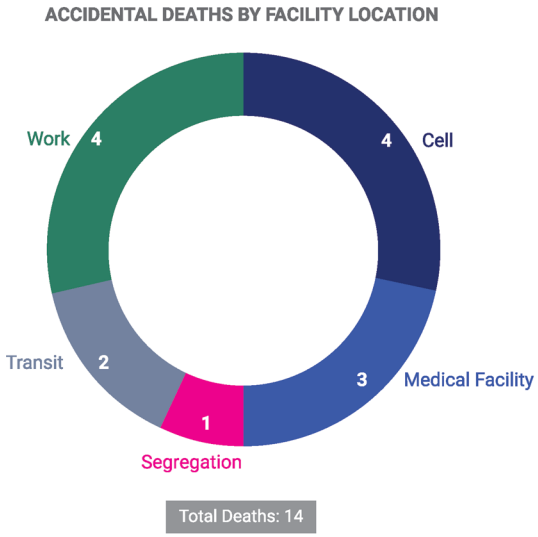
The average number of days incarcerated was lower in parish jails than state or private prisons. The length of time a person was incarcerated prior to death by accident ranged from 5 days to over 18 years. Only one accidental death occurred in a private facility. One of the parish deaths occurred after 10 days incarcerated at the facility where they died, but records indicate the death occurred as part of work-release and therefore it is likely the person was previously incarcerated at a different facility.



All of the known accidental deaths were male. In contrast to most other categories of death, White men are the majority of deaths by accident (64%) compared to Black men (29%).

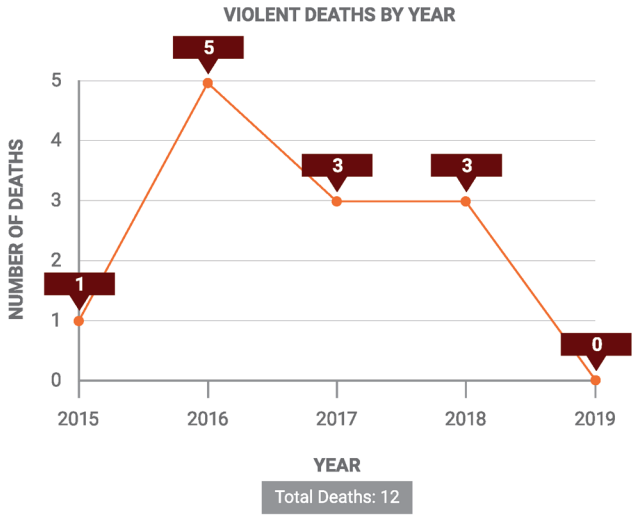


The two leading locations for accidental deaths were cells inside the facilities and work outside of the facilities. For deaths in cells, three of the accidental deaths were due to head injuries, of which one is described as the result of falling down. The fourth death did not indicate how the injury leading to death was sustained. Of the four deaths occurring as a result of work, two involved drowning (one when a boat collapsed on the Mississippi River); one involved falling from the bed of a truck travelling down a U.S. highway; and one involved an unspecified “accidental injury to self” at work.

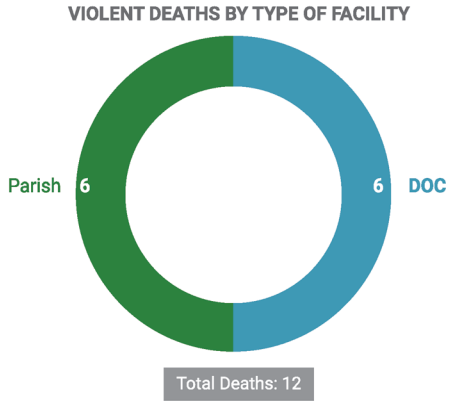


Violence

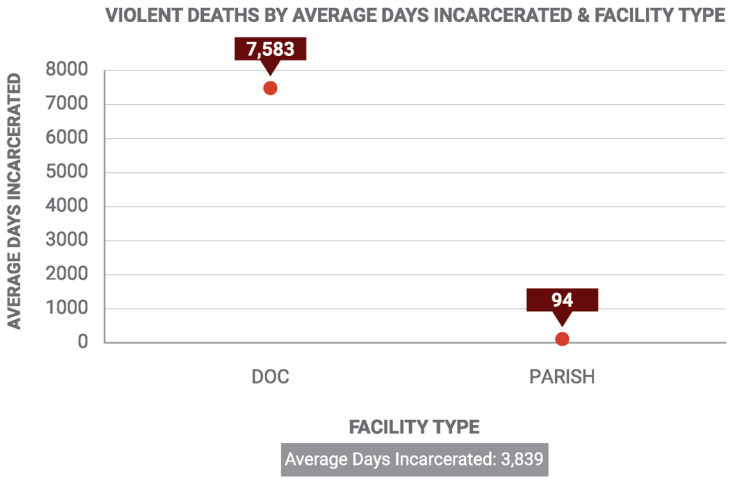
Deaths due to violence were one of the least common forms of deaths behind bars in Louisiana. This may be due to coding errors or judgment by reporting facilities, since at least one death coded as accidental was in fact an officer-involved shooting. There were zero deaths due to violence reported for 2019. All of the deaths related to violence involved altercations between incarcerated people. Most of the deaths due to violence were the result of head injuries sustained during the assault, but one was due to choking by another incarcerated person.



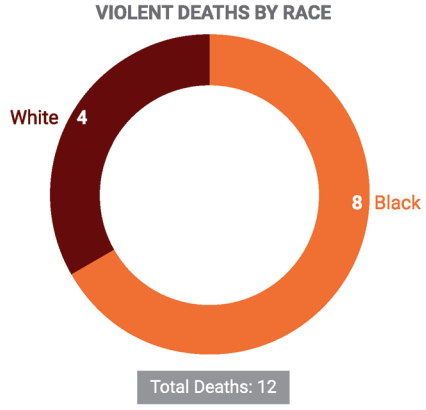
State prisons and parish jails are the only recorded types of facilities reporting deaths due to violence. Neither juvenile nor private facilities reported deaths due to violence. Three of the violent deaths occurring in parish jails occurred in a single facility, namely East Baton Rouge Parish Prison.



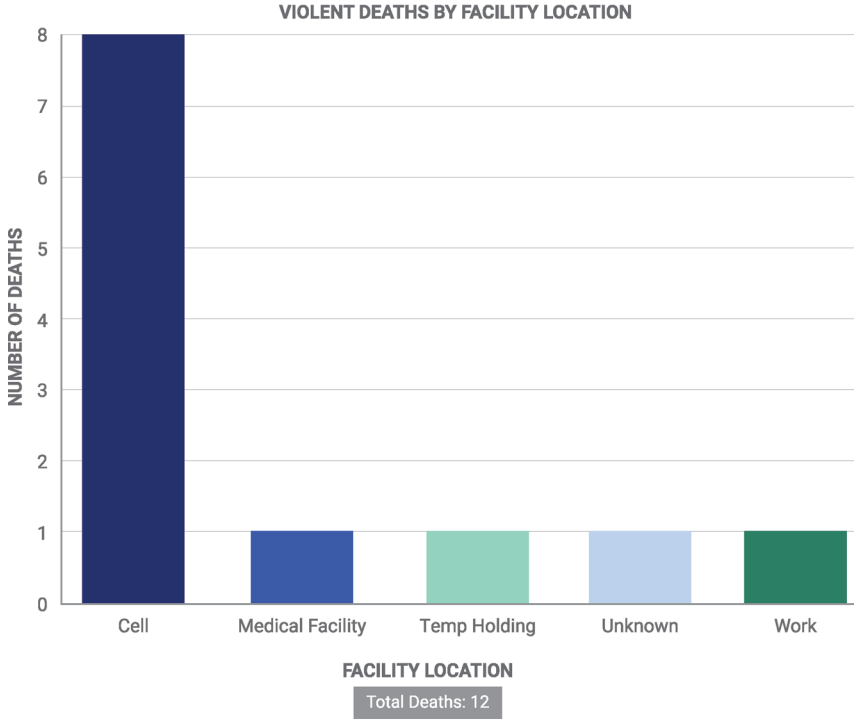
The average number of days incarcerated prior to violence leading to death was shorter for parish jails than state prisons. Two of the violent deaths in parish jails occurred within 24 hours of admission and the remaining deaths in parish jails occurred within the first year of incarceration (between 10 to 228 days). Violent deaths in state prisons occurred later in incarceration, ranging from 9 to 27 years behind bars before death.



African-Americans comprise two-thirds of reported deaths due to violence, compared to one-third of Whites. Only one of the deaths was female.



Two-thirds of deaths due to violence occurred in cells, the majority of which involved assaults and blunt force trauma leading to head injuries. This would seem to indicate that the violence was not a product of contraband or homemade weapons, but does implicate supervision and observation policies of these facilities. The timing of these deaths was evenly spread across morning, afternoon, evening, and overnight. Notably, two of the three reported violent deaths occurring in East Baton Rouge Parish Prison happened in the evening.



CONCLUSION

This report provides the first ever analysis of deaths behind bars in Louisiana in prisons, jails, & youth detention centers. 38 out of 132 local, private, or federal facilities have not provided requested records to date. Though incomplete, the 786 documented deaths are a significant step to greater transparency of these public institutions.

While not all deaths behind bars are necessarily preventable, prisons and jails should ideally have lower death rates than the general public due to the physical proximity of medical care behind bars, 24-hour staffing and supervision, and reduced probability of certain types of deaths, such as car accidents, due to incarceration.

A person's risk of death behind bars should not depend on their facility assignment. Although DOC prioritizes placement of people with serious medical needs in select state prisons, such as Louisiana State Penitentiary, medical-related deaths also occurred in parish jails where there are less robust medical systems in place.

Death behind bars can impact anyone incarcerated, regardless of their crime or guilt or innocence. Some incarcerated people died relatively early in their judicially determined sentences. Others died after completing the majority of their sentence while enrolled in work release programs designed to aid their transition home. Fourteen percent of deaths were of people who had only been accused of a crime, without a chance to prove their innocence, or to be found guilty.

Prison, jail, and youth detention administrators can and should use this data to compare the operation of their individual facilities to others. In some cases, the trends identified implicate institutional policies and practices, which should be reviewed with the aim of decreasing deaths behind bars.

State and local leaders should officially collect, track, analyze, and publish this data for the public. This report can serve as an important baseline for future research and analysis, but continued transparency of our public institutions is needed for sustainable improvements and public support.

ACKNOWLEDGMENTS

Author

Professor Andrea Armstrong (JD, MPA) joined the Loyola University New Orleans, College of Law faculty in 2010. She is a national expert on prison and jail conditions and is certified by the U.S. Department of Justice as a Prison Rape Elimination Act auditor. Her research focuses on the constitutional dimensions of prisons and jails, specifically prison labor practices, the intersection of race and conditions of incarceration, and public oversight of detention facilities. She teaches in the related fields of constitutional law, criminal procedure, law and poverty, and race and the law. Prof. Armstrong also received a three-year Interdisciplinary Research Leader grant from the Robert Wood Johnson Foundation, shared with the Voice of the Experienced and LSU Center for Healthcare Value and Equity, to examine the effects of incarceration on health service use in Louisiana, currently a global and national leader in incarceration rates. Prof. Armstrong is a graduate of Yale Law School, the Princeton School of Public and International Affairs, and New York University.

Project Participants

This project would not have been possible without the hard work and dedication of the following Loyola University New Orleans law students enrolled in the incarceration seminar.

Gautami Bamba
Sierra N. Blanchard
Ruth M. Blanco
Brandan T. Bonds
Meredith M. Booker
Grace N. Bronson
Aliscia K. Burkett
Curtis J. Case
Alexis L Chapital
Anne L. Culotta
Zora Djenohan
Avery P. Dubois
Sarah K. Dunham
Ashlii M. Dyer
Kimberly M. Fanshier
Kevin B. Fitzgerald
Amber M. Fletcher
Delia C. Gavin
Jenna R. Grant
Christina K. Guzman
Hailey N. Kilpatrick
Nyanna N. Miller
Jillian Morrison
Chloe M. Rippel
Angel J. Salome
Laura Sanchez Fowler
Anna M. Singleton
Lisa C. Soyars
Derek K. Stadtlander
Bianca L. Velez
Jimmy D. Whitehead
Dominic A. Wilson

Special thanks are also due to Loyola Law students Jenna Grant, Grace Bronson, Delia Gavin, Meredith Booker, and Gautami Bamba, who provided research assistance and project support beyond their participation in this seminar.

Adjunct professors/staff attorneys at the Promise of Justice Initiative Erica Navalance and Shanita Farris, alongside Rob Harrison (LCSW) provided invaluable guidance, advice, and support to these students and the project as a whole.

In addition, the Incarceration Transparency project website, www.incarcerationtransparency.org, and database are a product of the creativity and leadership of Loyola University New Orleans College of Law Prof. Judson Mitchell and students enrolled in his law and technology clinic.

Breanna L. Blot
Curtis J. Case
Brandi Cormier
Avery P. Dubois II
Stephen M. Fant
Mary K. Fernandez
John W. Gillette Jr.
Nicole Goots
John Halfacre
Jamia P. Love
Brianna A. Nevels
Andrew C. Rayford
Alexander C. Smith
Clayton L. Wright
John William Zimmer III

Arnold Ventures and the Law Visiting Committee Professorship at Loyola University New Orleans, College of Law provided financial support for this project.

APPENDIX

List of Tables

Deaths by Facility

	2015	2016	2017	2018	2019	Total
DOC	**119**	**116**	**118**	**110**	**95**	**558**
Allen Correctional Center				1		1
B.B. Rayburn Correctional Center - DOC	1	2	4	1	3	11
David Wade Correctional Center - DOC	5	6	4	9	6	30
Dixon Correctional Institute - DOC	9	12	9	5	6	41
Elayn Hunt Correctional Center - DOC	42	32	39	30	32	175
Louisiana State Penitentiary (Angola Prison)	56	53	52	50	41	252
Lousiana Correctional Institute for Women - DOC	2	3	6	2	2	15
Raymond Laborde Correctional Center - DOC	4	8	4	12	5	33
Juvenile			**2**		**2**	**4**
Swanson Center for Youth at Monroe - DOC / Youth			1			1
Ware Youth Center - DOC Youth			1		2	3
Parish	**45**	**34**	**48**	**39**	**26**	**192**
Acadia Parish Jail			2		2	4
Ascension Parish Jail				1		1
Avoyelles Marksville Detention Center	1	1		3		5
Avoyelles Parish Simmsport Detention				1		1
Baton Rouge City Jail		1	1			2
Bienville Parish Jail			1			1
Bogalusa City Jail	1					1
Bossier Parish Maximum Security Facility			1			1
Caddo Parish Correctional Center		2	1	2	1	6
Calcasieu Parish Correctional Center	1	1		1	1	4
Calcasieu Sheriff's Prison				1		1
Caldwell Parish Correctional Center	1					1
City of Kenner Jail	1			1		2
City of Morgan City Jail	1					1
City of West Monroe Jail	1					1
Claiborne Parish Detention Center			2			2

Concordia Correctional Facility	3	2			1	6
Concordia Parish Work Release Facility			1	1		2
East Baton Rouge Parish Prison	3	6	5	4	4	22
East Baton Rouge Work Release		2			1	3
East Feliciana Parish Work Release			1			1
Evangeline Parish Jail	1					1
Franklin Parish Detention Center	2		1			3
Iberia Parish Jail		2				2
Iberville Parish Jail	1					1
Jefferson Davis Parish Jail		1				1
Jefferson Parish Correctional Center	4	1	6	4	4	19
Lafayette Parish Correctional Center	2	1		2		5
Lafourche Parish Detention Center				1		1
Lafourche Parish Transitional Work Program			1			1
Lincoln Parish Detention Center				1		1
Livingston Parish Detention Center		1	1			2
Livingston Parish Transitional Work Program				1		1
Madison Parish Correctional Center & Work Release Facility				1		1
Morehouse Parish Detention Center		1				1
Morehouse Parish Jail	3					3
Natchitoches Parish Detention Center			2			2
Orleans Parish Prison & TDC	3	2	7	2		14
Other	1	1				2
Ouachita Correctional Center		2	1	4	2	9
Plaquemines Parish Detention Center				1		1
Rapides Parish Detention Center I, II, III	1	1	2		2	6
Riverbend Detention Center		1	1	2	1	5
Sabine Parish Correctional Division		1				1
Saint Bernard Parish Jail			1			1
Shreveport City Jail		1				1
Southwest TWP	2				1	3
St. Charles Parish Nelson Coleman Correctional Center		1	1			2

St. Helena Parish Jail				1		1
St. Landry Parish Jail	1					1
St. Tammany Parish Jail	2		2	1		5
Sulphur City Jail			1			1
Tangipahoa Parish Prison	1	1	1	1	1	5
Tensas Parish Detention Center	1					1
Terrebonne Parish Criminal Justice Complex	2	1	1			4
Union Parish Detention Center	2					2
Vermilion Parish Law Enforcement Center	1					1
Vernon Parish Correctional Facility			2			2
Washington Parish Jail	1		1		1	3
Webster Correctional Facility (Bayou Dorcheat Correctional Facility)	1			1	1	3
Webster Parish Jail			1	1	1	3
West Baton Rouge Parish Detention Center					1	1
West Feliciana Parish Work Release Facility					1	1
Private	**10**	**12**	**2**	**6**	**2**	**32**
Allen Correctional Center	3	5				8
Catahoula Correctional Center - LaSalle		1	1	1	1	4
City of Faith Monroe House (Male & Female)	1				1	2
Jackson Parish Correctional Center - LaSalle		1		1		2
LaSalle Corrections Center	1			1		2
Richland Parish Detention Center (Males) - LaSalle	1					1
Richwood Correctional Center - LaSalle		1				1
River Correctional Center - LaSalle		1		3		4
South Louisiana Correctional ICE Processing Center	1					1
Winn Correctional Center	3	3	1			7
Total	**174**	**162**	**170**	**155**	**125**	**786**

EXHIBIT 2

JULIAN C. WHITTINGTON
SHERIFF
PH: (318) 965-2203
FAX: (318) 965-3505

BOSSIER PARISH SHERIFF'S OFFICE
POST OFFICE BOX 850
BENTON, LA 71006

September 28, 2021

[redacted]
Loyola University
JD Candidate 2022

RE: PUBLIC RECORDS REQUEST

Dear Mr. [redacted],

The Department of Justice (DOJ) has not yet requested statistical data concerning "In-Custody Deaths" for calendar year(s) 2020 and/or 2021. Moreover, statistical data collection for calendar year 2021 is currently incomplete, and DOJ reporting typically runs one (01) year behind. As such, most recently during the year 2020, the Bossier Parish Sheriff's Office reported statistical data pertaining to calendar year 2019. For these reasons, I regret to inform you that the Bossier Parish Sheriff's Office does not possess any document(s) responsive to your request regarding DOJ reporting of "In-Custody Deaths" (2020-2021).

Please feel free to contact me with any questions and/or concerns, thank you.

Respectfully,
Bruce Bletz Jr.
Lt. Bruce Bletz Jr. #159
Risk Management/Staff Services
Office (318) 935-2077

LOYOLA UNIVERSITY NEW ORLEANS

[redacted]@my.loyno.edu>

public records request

1 message

Sherry Thompson <thompsons@tpso.org> Tue, Oct 12, 2021 at 12:38 PM
To: [redacted]@my.loyno.edu

I will be forwarding the report for 2020. The Deaths In Custody report is no longer required to be done so I will send the 2020 and that is all there is.

Thanks so much,

--
Lt. Sherry Brown
985-748-3363
Tangipahoa Parish Jail
Assistant Warden

LOYOLA UNIVERSITY NEW ORLEANS

[redacted]@my.loyno.edu>

Administrative Public Records :: Z000257-101221

1 message

St. Tammany Parish Sheriff's Office Records Center <stpso@govqa.us> Wed, Oct 13, 2021 at 3:47 PM
To: "[redacted]@my.loyno.edu" <[redacted]@my.loyno.edu>

--- Please respond above this line ---

ST. TAMMANY PARISH
SHERIFF'S OFFICE

RE: Public Records Request of October 12, 2021, Reference # Z000257-101221

Dear Mr./Ms. [redacted],

In response to your Public Records Request received by the St. Tammany Parish Sheriff's Office on October 12, 2021 and after a diligent search, we find that we have no records responsive to this request. The St. Tammany Parish Jail last reported inmate deaths in custody to the U.S. Department of Justice (DOJ), Bureau of Justice Statistics (BJS) for the calendar year 2019. Jail Administration has been advised by the DOJ that the BJS is no longer receiving and compiling inmate death in custody information as the American Jail Association (AJA) is now responsible for this function. Please be advised that we are in the process of contacting the AJA to obtain further information regarding the new and/or updated reporting procedures. Unfortunately, we are unable to offer a timeframe for when we anticipate receiving the aforementioned information. Should you wish to inquire again at a later date, please do so via our online Public Records Center.

Sincerely,

Jeannine Buckner
Legal Department

To monitor the progress or update this request please log into the St. Tammany Parish Sheriffs Office Public Records Center

Powered by GovQA

Gmail [redacted]@my.loyno.edu>

Public Records Request

Christy Jacobs <cjacobs@assumptionsheriff.com> Fri, Oct 15, 11:35 AM
To: [redacted]@my.loyno.edu>

Please see the response below from our Warden regarding your inquiry about "Deaths in Custody".

The APDC did not have to file a report since we did not have a "Death In Custody" in calendar year 2020 and 2021. In an abundance of caution, I tried to submit a report but the system would not allow that information to be submitted

[Quoted text hidden]

LOYOLA UNIVERSITY NEW ORLEANS

[redacted]o@my.loyno.edu>

Public Records Request

2 messages

Julie Scioneaux <julie.scioneaux@stjamessheriff.com> Wed, Sep 15, 2021 at 9:21 AM
To: "[redacted]@my.loyno.edu" <[redacted]@my.loyno.edu>

Good morning [redacted],

I have attached the Mortality in Corrections Institutions forms for the years 2018 and 2019. We were notified in March of this year that the BJS's statistical program ended in November of 2020, so we did not submit any data for 2020.

St. James Parish Sheriff's Office did not have any in custody deaths for the year 2020.

If you need anything else, please let me know.

Captain Juliette Scioneaux
Chief of Detectives
Information Technology Supervisor
St. James Parish Sheriff's Office
P.O. Box 83
Convent, LA 70723
julie.scioneaux@stjamessheriff.com
Desk: (225) 562-2507

Xerox Scan.pdf
623K

[redacted]@my.loyno.edu> Tue, Sep 21, 2021 at 9:45 AM
To: Julie Scioneaux <julie.scioneaux@stjamessheriff.com>

Thank you for providing this information.

Best,

[redacted]
J.D. Candidate, Class of 2022
Loyola University New Orleans College of Law
[redacted]

[Quoted text hidden]

EXHIBIT 3

Data Inconsistences for Federal Data Collection on Mortalities in Correctional Institutions
Prof. Andrea Armstrong, Loyola University New Orleans College of Law
REVISED Oct. 29, 2021

This memo provides the following information:
Part I provides an overview of data collection instruments, with links to the actual forms.
Part II identifies important data that will no longer be collected under the BJA survey.
Part III identifies data inconsistencies for data collected by both BJS and BJA.

Overall the most important data gaps for deaths behind bars are:

- Lack of population and admissions information, since these numbers can be used as the denominator to determine mortality rates for incarcerated population. (Part II)
- Lack of information on facilities with no deaths (Part II)
- No data collected for decedent offenses, trial status, mental health stays, location of deaths and incidents leading to death, medical examiner review, pre-existing conditions, and types of medical care received for illness related deaths. This information will no longer be available for analysis. (Part II)
- Lack of specificity for medically related causes of death. This is particularly important for determining which diseases/illnesses are the leading causes of death. (Part III)
- Type of facility data by BJA will obscure juvenile facility deaths, unless the Census Bureau continues its data collection (Part III)

Additional inconsistences and data gaps are noted in the tables in Parts II and III

I. Overview of types of data collection instruments and agencies for deaths behind bars:

A. BJS (Bureau of Justice Statistics for data 2014-2019)

1. Jails CJ-9, CJ-9A
   - CJ-9A -Summary form for Deaths in Custody information. This will have the total number of deaths for a calendar year
   - CJ-9 -If there are deaths at a facility they will submit this form for each individual who died and provide information about that individual's death and circumstances surrounding their incarceration.

2. Private or multi-jurisdictional facilities CJ-10, CJ-10A
   - CJ-10A -Summary form for Deaths in Custody information. This will have the total number of deaths for a calendar year
   - CJ-9 -If there are deaths at a facility they will submit this form for each individual who died and provide information about that individual's death and circumstances surrounding their incarceration.

3. State prisons NPS-4, NPS-4A
   - NPS-4A – Summary form for Deaths in Custody information. This will have the total number of deaths for a calendar year
   - NPS-4 - If there are deaths at a facility they will submit this form for each individual who died and provide information about that individual's death and circumstances surrounding their incarceration.

B. BJA (Bureau of Justice Assistance for data 2020-2021)

1. "DCRA Performance Measure Questionnaire" form
   This appears to be the form for all jails, state and private prisons and juvenile detention centers but DCRP 2013 requires federal data collection as well.[1]

C. Census Bureau (for juveniles for all years)

1. CJ-14/15 Juvenile census form, which includes question on deaths in facilities.
   - CJ-15 for even years and CJ-14 for odd years.
   - It is unclear if the Census Bureau will continue to collect this information.

II. Missing Data in BJA Data Collection

BJA will no longer collect the following pieces of information:

Missing Data	Significance
Admissions/Population Q1, 2 of CJ-9A Summary form 1. How many persons under the supervision of your jail jurisdiction were… 1a. CONFINED in your jail facilities on December 31, 2010? (male/female) 1b. ADMITTED to your jail facilities during 2010? (male/female) 2. Between January 1, 2010, and December 31, 2010, what was the average daily population of all jail confinement facilities operated by your jurisdiction? (male/female)	This data is critical for calculating mortality rates at the facility and state level. Admissions and population information can be the denominator for determining rates of death. Determining mortality rates for incarcerated populations is important so we can assess whether the rate of deaths behind bars is similar or different from mortality rates for the same causes generally. For example, Prison Policy Institute concluded that mortality rates for suicides in jail are significantly higher than suicide rates generally in the U.S.,[2] which would be impossible without population data.
Facilities with ZERO DEATHS – Q3, of CJ-9A Summary form Between January 1, 2010, and December 31, 2010, how many persons died while under the supervision of your jail jurisdiction? (male/female)	The BJA form is statewide and does not require reporting for facilities with zero deaths. This information is important to help identify facilities (and facility characteristics, such as size) that do not have death outcomes and may be models for other jails that are death hotspots. This data led to the BJS finding that approximately 80% of jails do not have a death in a given calendar year.[3]
Offenses for detention Q10 - For what offense(s) was the inmate being held?	Will not be able to analyze the offenses for people who died behind bars, for example are they

[1] See also BJA Death in Custody Report Act Factsheet, BJA Death in Custody Report Act Performance Management Tool FAQ,

[2] Leah Wang, Prison Policy Institute, Rise in jail deaths is especially troubling as jail populations become more rural and more female, (June 23, 2021)

[3] See e.g. E. Ann Carson, U.S. Dep't of Justice, Bureau of Just. Stat, Mortality in Local Jails, 2000-2018 – Statistical Tables, 2 (April 2021)(noting 78% of jails in 2018 reported no deaths)

	related to substance abuse, non-violent or violent crimes.
Trial status Q11 - What was the inmate's legal status at time of death? (convicted-new, convicted-parole/probation violation; unconvicted; other)	Will not be able to determine how many deaths were pre-trial, for example. My back of the envelope calculations based on BJS data are roughly 21% of U.S. carceral deaths are pre-trial.[4]
Mental health treatment Q12 - Since admission, did the inmate ever stay overnight in a mental health observation unit or an outside mental health facility?	Will not be able to assess role of mental health status in manner of death without this information, particularly for suicides. Suicides are the second leading category of deaths in local jails,[5] and state and federal prisons.[6] "From 2001 to 2019, suicides accounted for 5% to 8% of all deaths among state and federal prisoners and 24% to 35% of deaths among local jail inmates."[7]
Location of death WITHIN facility Q13: Where did the inmate die? Checkbox options include: In a general housing unit within the jail facility or in a general housing unit on jail grounds; In a segregation unit; In a special medical unit/infirmary within the jail facility; In a special mental health services unit within the jail facility; In a medical center outside the jail facility; In a mental health center outside the jail facility; While in transit; Elsewhere - Please Specify	This information is important to determine where deaths (not the precipitating incident if applicable) occurred. If deaths are located in non-medical spaces, this may implicate the response times/practices by the facility. BJS also specifically includes solitary confinement spaces, which are completely omitted from BJA data collection.
Medical examiner review of cause of death Q14: Are the results of a medical examiner's or coroner's evaluation (such as an autopsy, postmortem exam, or review of medical records) available to establish an official cause of death?	This information is critical for data rigor by linking the cause of death reported to BJS to findings from a medical evaluation. In addition, this data allows researchers to determine to what extent deaths are reviewed by medical authorities.

[4] Bureau of Justice Statistics indicate that from 2001 to 2018, 86,173 people died nationwide in jails and federal and state prisons, of which 18,299 were in jails. See E. Ann Carson, Bureau of Just. Stat., U.S. Dep't of Just., Mortality in State and Federal Prisons 20012018—Statistical Tables 1 (2021) (identifying 67,874 deaths in federal and state prisons); E. Ann Carson, Bureau of Just. Stat., U.S. Dep't of Just., Mortality in Local Jails 2001–2018—Statistical Tables 6 tbl.1 (2021) (listing number of deaths per year in 2000 and 2008–2018, including a total of 11,106 deaths 2008-2018). For the years 2001-2007, 7,193 people died in custody in jails. Margaret Noonan, Bureau of Just. Stat., U.S. Dep't of Just., Mortality in Local Jails 2000–2007, 7 tbl. 8 (2010)(listing total number of deaths 2000-2007).

[5] E. Ann Carson, U.S. Dep't of Justice, Bureau of Just. Stat, Mortality in Local Jails, 2000-2018 – Statistical Tables, 3 (April 2021)

[6] E. Ann Carson, U.S. Dep't of Justice, Bureau of Just. Stat., Mortality in State and Federal Prisons,2001-2018 – Statistical Tables, 2 (April 2021)

[7] E. Ann Carson, U.S. Dep't of Justice, Bureau of Just. Stat., Suicide in Local Jails and State and Federal Prisons, 2000–2019 – Statistical Tables, 1 (Oct. 2021)

Checkbox options include: Yes, Evaluation complete—results are pending, No evaluation is planned.	
Incident location (compared to location of death) Q16: Where did the incident (e.g., accident, suicide, or homicide) causing the death take place? Checkbox options include: NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related; In the jail facility or on the jail grounds including a) In the inmate's cell/room b) In a temporary holding area/lockup In a common area within the facility (e.g., yard, library, cafeteria) c) In a segregation unit d) In a special medical unit/infirmary e) In a special mental health services unit f) Elsewhere within the jail facility; Outside the jail facility (e.g., while on work release or on work detail); Elsewhere (specify)	Will not be able to analyze the location of incidents. The location in which incidents occur can be useful for determining if particular locations within the jail are more unsafe than others. This data was critical for our finding that 43% of suicides in Louisiana jails and 67% of suicides in juvenile facilities occurred in solitary confinement/segregation.[8] "Suicides in segregation are of particular concern, since segregation settings usually entail a higher level of individual supervision/observation than general shared cell or dorm settings combined with more restrictive policies on items allowed in a segregation cell."[9]
Medical care received prior to death Q18 - Excluding emergency care provided at the time of death, did the inmate receive any of the following medical services for the medical condition that caused his/her death after admission to your correctional facilities? Check box options include N/A (accidental injury, intoxication, suicide, homicide) OR for illness deaths (evaluation by physician/medical staff, diagnostic tests (X-ray, MRI); Medications; Treatment/care other than medications; surgery, confinement in special medical unit;	Will not be able to analyze or assess facility medical treatment related to death-outcomes for carceral healthcare. Medical illnesses are the overwhelming leading cause of death in state and federal prisons and local jails.
Pre-existing condition Q19 - Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? (check box options include N/A (accidental injury, intoxication, suicide, homicide) OR Pre-existing medical condition, Deceased developed condition after admission, Could not be determined)	Will not be able to analyze the prevalence of pre-existing conditions. This information was critical to our finding that 53% of Louisiana prison and jail deaths due to medical illness were NOT due to a pre-existing condition and therefore were exclusively diagnosed and treated by carceral healthcare.[10]

[8] Andrea Armstrong, Louisiana Deaths Behind Bars 2015-2019, 28 (2021).
[9] Id. at 27.
[10] Andrea Armstrong, Louisiana Deaths Behind Bars 2015-2019, 26 (2021).

III. Data inconsistency between BJA and BJS data instruments

Issue	BJA	BJS CJ9 series for jails	Problem with BJA
Summary info, Q1 - BJA	• No summary form, only collects number of deaths	• Summary form includes male/female data on population at year end, admissions, average daily population and total number of deaths. (Q1-3, CJ-9A)	• No data on admissions, average daily population, population at end of year. CAN NOT CALCULATE MORTALITY RATE WITHOUT POPULATION[11] . This will also complicate the ability to disaggregate and analyze small facilities compared to mid-size or larger facilities.
	• Asks for deaths "in your state" AND same form is used regardless of facility type (jail, prison, private)	• Summary form is specific to type of facility and asks for deaths in that "jurisdiction" (Q4, CJ-9A)	• Implies BJA form is filled out by state for all deaths, including those in local jails. In Louisiana, the state DOC does not collect information on deaths of people detained pre-trial in local jails, but this may change as BJA implementation moves forward.
Decedent Information Q2-BJA	• Collects only year of birth	• Collects Day, Month, and Year for birthday (Q4, CJ-9)	• Results in inaccurate data for age at time of death, making analysis on age and disease less reliable
	• Allows for other "gender identify" as option	• Limited to male/female checkboxes (Q5, CJ-9))	• While important to allow other identities, this does make BJA data inconsistent from BJS data
	• Race includes "unknown" category	• BJS has textbox entry for "other race" (Q7, CJ-9)	• Less accurate data on race with new category and does not require reporter to identify race
	• Ethnicity includes "unknown" category	• BJS requires choice between Yes and No for whether a person is of "Hispanic, Latino, or Spanish origin" (Q6, CJ-9)	• Less accurate data for ethnicity with new category and does not require reporter to identify ethnicity
Death Information Q3	• Does not ask for holding authority, i.e. US Marshals, ICE, BIA, state or local	• Asks for holding authority	• Jails often house people on behalf of other authorities and analysis on deaths relative to their holding

[11] BJA may be relying on other data surveys to get population information, but that data may not be at the facility or even local level, but instead at the statewide level.

	BUT does collect arresting agency in Q4		authority is no longer possible. Arresting agency data might lessen the impact of excluding holding authority, but some people will be arrested by one agency (local police), but held for a different agency (ICE).
	• Time of death is the exact time of death	• Time of incident leading to death is reported by period (morning, afternoon, evening, overnight) (Q17, CJ-9)	• BJA data asks for time of death, BJS data asks for time of incident leading to death. Review of past forms indicates jurisdictions complete this even for medical causes of death and likely just enter time of death. Can make data consistent with BJS data, but will have to categorize time of death and will not be exact.
	• Includes facility address	• Does not include facility address for death specifically, but can be inferred for local jails from form, which includes address of reporting authority	• Inclusion of facility address could be helpful for determining distance between nearest medical facility and jail.
	• Type of facility is collected, but juvenile deaths included in "other state or local," so will be impossible to disaggregate	• Different forms by type of facility, and a specific form for juvenile facilities	• Deaths in juvenile facilities will be difficult to extract from the data. Researchers may be able to identify through a combination of age and "other state or local" but will be difficult to disaggregate those held in state juvenile facilities and those in local juvenile facilities. Note that some states hold 15-16 year olds in adult facilities and not juvenile facilities.
	• Type of facility options do not include federal prisons	• Form for prisons includes state and federal (NPS-4)	• Based on the form, it is not clear BJA Data will not include deaths in federal prisons. - This data may be collected in a different

			non-public data instrument, as DCRP 2013 law requires federal data collection.
Manner of death Q5	• Collects cause of death data as follows: - Accident - Use of force - Homicide (between incarcerated people) - Natural Causes - Suicide - Unavailable (pending investigation, must list agency investigating, approx. end date for investigation and instruction to update) - Other (with instruction to explain)	• Collects cause of death data as follows (Q15): - Accidental Alcohol/Drug (describe) - Accidental Injury to self (describe) - Accidental Injury by other (eg vehicular transport); - Illness (excluding AIDS-related, specify illness) - AIDS - Suicide - Homicide (describe) - Other cause (specify)	• BJA data provides far less data on the cause of death - Less specificity on the type of accident - does NOT collect specific disease/illness data under "natural causes" - does NOT disaggregate deaths due to AIDS; - BUT may provide more info by separating homicides into two categories (between incarcerated people and those involving use of force)
Other information (Q6)	• Circumstances of death – open-ended question for details of death, such as number and affiliation of involved parties, location, other context)	• Space provided for additional details at end of survey	• BJA's open-ended question will mean inconsistent data collection for the incident location and other data specifically asked in other BJS questions

Department of Justice

STATEMENT OF
MAUREEN HENNEBERG
DEPUTY ASSISTANT ATTORNEY GENERAL
OFFICE OF JUSTICE PROGRAMS
U.S. DEPARTMENT OF JUSTICE

BEFORE THE

SENATE COMMITTEE ON HOMELAND SECURITY AND GOVERNMENT AFFAIRS
PERMANENT SUBCOMMITEE ON INVESTIGATIONS

FOR A HEARING ENTITLED
"UNCOUNTED DEATHS IN AMERICA'S PRISONS AND JAILS: HOW THE DEPARTMENT OF JUSTICE FAILED TO IMPLEMENT THE DEATH IN CUSTODY REPORTING ACT"

PRESENTED

SEPTEMBER 20, 2022

Statement of
Maureen Henneberg
Deputy Assistant Attorney General
Office of Justice Programs
U.S. Department of Justice

Before the Senate Committee on Homeland Security & Governmental Affairs
Permanent Subcommittee on Investigations

For a Hearing Entitled
"Uncounted Deaths in America's Prisons and Jails:
How the Department of Justice Failed to Implement
the Death in Custody in Reporting Act"
September 20, 2022

Chairman Ossoff, Ranking Member Johnson, and distinguished members of the Committee, thank you for the opportunity to speak with you today about the Department of Justice's ("Department" or "DOJ") implementation of the Death in Custody Reporting Act and the mechanisms by which DOJ can improve the conditions of incarceration in state and local prisons and jails. My name is Maureen Henneberg, and I serve as the Deputy Assistant Attorney General for Operations and Management for the Office of Justice Programs at the Department of Justice.

The Death in Custody Reporting Act of 2013 (DCRA of 2013) requires states and territories that receive funding under the Edward Byrne Memorial Justice Assistance Grant (JAG) Program, and all federal law enforcement agencies, to report certain information regarding deaths that occur in prisons, jails, or during the process of arrest to the Attorney General. DCRA reporting requirements apply to all deaths that occur in federal, state, or local custody. DCRA directs the Attorney General to carry out a study to determine the means by which this information can be used to reduce the number of deaths in custody, and more specifically, to examine the relationship, if any, between the number of such deaths and the actions of management of such jails, prisons, and other specified facilities relating to such deaths.

DCRA of 2013 addresses a profoundly important issue, which is of great consequence to the legitimacy and integrity of the criminal and juvenile justice systems, to the lives of the people who come into contact with the justice system, and to the family members and loved ones of those who have died in custody. Growing awareness of deaths in custody has increased demands for criminal and juvenile justice reform. The Department recognizes the importance of collecting complete and accurate data to inform strategies for reducing deaths in custody. Such data are essential for producing appropriate findings and drawing meaningful conclusions about factors that may contribute to unnecessary or premature deaths in custody, and promising practices and policies that may reduce deaths in custody.

The Office of Justice Programs (OJP) has primary responsibility for administering DCRA of 2013, through its subcomponents the Bureau of Justice Statistics (BJS), Bureau of Justice Assistance (BJA), and National Institute of Justice (NIJ).

DCRA of 2000

The first DCRA statute (P.L. 106-297) (hereinafter, DCRA of 2000) was signed into law on October 13, 2000, as an amendment to the Violent Crime Control and Law Enforcement Act of 1994. At that time, DCRA of 2000 required states to provide assurances that they will follow Attorney General guidelines for reporting, on a quarterly basis, information regarding "the death of any person who is in the process of arrest, is en route to be incarcerated, or is incarcerated at a municipal or county jail, State prison, or other local or State correctional facility (including any juvenile facility)." Under the law, covered states were required to report the name, gender, race, ethnicity, and age of the deceased; the date, time, and location of death; and a brief description of the circumstances surrounding the death.

BJS implemented DCRA of 2000, and successfully collected and reported on deaths that occurred in the custody of state prisons and local jails but continued to experience challenges in the collection of complete and accurate data on deaths that occurred in the process of arrest. DCRA of 2000 expired in 2006, but BJS continued to carry out annual data collections despite the law's expiration. Between 2005 and 2015, BJS published twenty reports on mortality in local jails and state prisons, and on arrest-related deaths (see Appendix A for a full list of BJS publications related to DCRA). These reports provided a wide variety of statistics and tables related to cause of death, decedent characteristics, and facility characteristics.

DCRA of 2013

An update to DCRA was signed into law on December 18, 2014, DCRA of 2013 (P.L. 113-242) (hereinafter "DCRA of 2013"), which was similar to its predecessor in requiring reporting on information on deaths in custody that occur in state prisons and local jails, or during the process of arrest, and information about the decedent and circumstances of the death. The 2013 version of the law also expanded on DCRA of 2000 in important ways, including requirements for reporting by federal law enforcement agencies and a study requirement focused on using DCRA reporting to identify ways to reduce deaths in custody. DCRA of 2013 also provided the Attorney General with the discretion to reduce JAG funding by up to 10% for states that did not comply with reporting requirements.

State Reporting and The Role of BJS and BJA

In December 2016, the Department determined that the connection between reporting requirements under DCRA of 2013 and administration of grant funding under the JAG program, and specifically the possible imposition of the penalty provision, precluded the involvement of BJS in data collection from states and local agencies. One reason was that the additional JAG enforcement and reporting compliance requirements under DCRA of 2013 were and are incompatible with BJS's authorizing statute as a federal statistical agency. Specifically, 34

U.S.C. § 10134 states that "data collected by the Bureau shall be used only for statistical or research purposes and shall be gathered in a manner that precludes their use for law enforcement or any purpose relating to a private person or public agency other than statistical or research purposes." The JAG enforcement and reporting compliance requirements under DCRA of 2013 also conflict with statistical directives stating that BJS "must function in an environment that is clearly separate and autonomous from the other administrative, regulatory, law enforcement, or policy-making activities" of the Department.[1] As a result, the Department announced that states would report DCRA data to BJA,[2] the agency that administers the JAG program. On December 16, 2016, the Department issued the *Report of the Attorney General to Congress* pursuant to the Death in Custody Reporting Act, which described plans for implementing DCRA of 2013 and some of the challenges involved, including the need to transfer the administration of DCRA state reporting requirements from BJS to BJA (2016 plan).[3]

The Plan to Implement DCRA of 2013 State Reporting

In 2017, the Department determined not to implement the 2016 plan out of concerns that it would overly burden state respondents and require them to submit information beyond what DCRA of 2013 explicitly requires. Similarly, it was determined that data would not be collected from local agencies because DCRA specifically requires states to submit data, and there is no requirement for local agencies to report. On June 11, 2018, the Department proposed a new plan[4] for implementing the DCRA of 2013 which focused on "provisions specifically required by the statute." As with the 2016 plan, it required state-level reporting only and transitioned the collection of data from BJS to BJA, but it also limited the incident-level reporting to those fields explicitly described in the statute and excluded any efforts related to open-source data confirmation or provision of state data collection plans.

The new plan went into effect in the first quarter of FY 2020, and JAG program state grantees started mandatory DCRA reporting for the October 2019-December 2019 reporting period, to align with their FY 2020 JAG progress reports. Under the new plan, DCRA reporting is considered a performance measure for the JAG awards, and State Administering Agencies that receive JAG awards were required to submit quarterly reports to BJA (rather than BJS) that respond to questions based on the requirements of the DCRA statute. To assist states with this transition, BJA and the JAG Training and Technical Assistance (TTA) provider, the National Criminal Justice Association , have provided, and continues to provide, DCRA-related TTA to

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[1] Office of Management and Budget, *Statistical Policy Directive No. 1: Fundamental Responsibilities of Federal Statistical Agencies and Recognized Statistical Units*, 79 Fed. Reg. 71,610, 71,615 (Dec. 2, 2014).

[2] BJA's mission is to provide leadership and services in grant administration and criminal justice policy development to support state, local, and tribal justice strategies to achieve safer communities. BJA focuses its programmatic and policy efforts on providing a wide range of resources, including training and technical assistance, to law enforcement, courts, corrections, treatment, reentry, justice information sharing, and community-based partners to address chronic and emerging criminal justice challenges nationwide.

[3] https://www.justice.gov/archives/page/file/918846/download.

[4] Death in Custody Reporting Act Collection, Notice for Proposed eCollection and eComments, 83 Fed. Reg. 27,023 (Jun. 11, 2018).

all 56 states and territories. TTA takes various forms including virtual trainings, assistance through the BJA Performance Measurement Tool Helpdesk, and one-on-one coaching. BJA has developed and continues to update reporting guidance and answers to frequently asked questions.[5] This guidance aligns with the information requirements set forth in DCRA of 2013, including for example, the requirement to report data regarding deaths that occur in juvenile facilities.

DCRA Data Quality and Completeness

Though well intentioned, DCRA of 2013 produced unintended consequences that adversely affected the Department's ability to produce complete and accurate information on deaths in custody. Prior to the enactment of DCRA of 2013, BJS achieved nearly a 100% response rate and was producing accurate and complete statistical information regarding deaths in local jails and state prisons. BJS collected arrest-related deaths, was transparent about shortcomings in this area (which related to completeness) and proposed mixed-methods solutions for improvements and produced many statistical reports on deaths in custody (see Appendix A). However, due to the JAG-related penalty requirements under DCRA of 2013, the Department can no longer engage BJS to collect information on state and local prison, jail, and arrest-related deaths. The Department also is unable to collect data directly from local agencies that possess this information because any such collection beyond the state reporting required by DCRA of 2013 would be duplicative. That is, if the Department implemented a separate collection of deaths in custody directly from state prisons, local jails, and law enforcement agencies in addition to the DCRA of 2013 requirement that the Department collect reports from state JAG grantees who seek the same information from agencies in their states, the responding agencies would be asked to report the same information twice in order to comply with the one statutory purpose.

DCRA of 2013 requires the Department to rely on the reports from 56 state- and territory-JAG-grant recipients that collect data using varied strategies and collectively have proven to be ineffective in producing complete and accurate information. As the Department reported in its 2016 Report to Congress, "[a]mong the more significant challenges, the Act requires states to report information that the states do not necessarily possess." The Department has determined that the enforcement mechanism under DCRA of 2013, should the Department use its discretion to apply JAG-grant penalties, would unfairly penalize state and territorial agencies, as well as units of local government, that are properly reporting DCRA data.

Analyses of state reporting under the requirements of DCRA of 2013 demonstrate data anomalies that indicate significant underreporting of deaths in custody in all three categories (*i.e.,* during arrest, in local jails, and in state prisons). This underreporting is widespread, and not the result of a small number of lagging or uncooperative states. The pattern of underreporting is more pronounced in some areas (*e.g.*, arrest-related deaths) than others (*e.g.*, prison deaths), but even where it is less pronounced, the degradation of data quality and completeness, as compared to previously available data collection methods, is considerable.

[5] https://bja.ojp.gov/funding/performance-measures/DCRA-Reporting-Guidance-FAQs.pdf.

The JAG Penalty

DCRA of 2013 provided the authority for the Department, at the discretion of the Attorney General, to impose a 10% penalty on JAG program funding on states that do not comply with reporting requirements. The Department, however, is concerned that implementing the JAG penalty may have unintended, negative consequences and has not implemented the penalty to date.

DCRA of 2013 would require the penalty to be applied to an entire state even when that state may be fully reporting to BJA what it has received from local agencies and that state is attempting to diligently collect the required data from its units of local government. In general, most states do not have laws requiring local agencies to report deaths in custody to state governments. Without such laws, state governments cannot compel local governmental agencies to report to them. State Administering Agencies have identified this lack of enforcement power over local jails and law enforcement agencies as one of their top concerns and challenges regarding compliance with DCRA reporting requirements. Such a state, if penalized under DCRA, would have a reduced JAG award, and thus have smaller amounts available for its own law enforcement activities and for its subawards to units of local government within the state who may be in full compliance with the DCRA reporting requirements. Notably, reducing the JAG award as a penalty for incomplete reporting may actually lead to an unintended consequence of lowering the amount of funds available and necessary to improve statewide DCRA reporting. Meanwhile, the reduction in JAG funding would have no effect on non-compliant units of government of that state that do not receive passthrough JAG funding. It is also important to note that the amount of JAG funding that reaches many agencies (*e.g.,* smaller agencies) is relatively small and may be viewed as an insufficient incentive or deterrent to compel compliance from those local agencies.

Next Steps for Implementing DCRA of 2013

Despite these challenges, DOJ's top priority for continuing to implement DCRA of 2013 is to improve the quality and completeness of state reporting, including improving the reporting from state and local agencies to State Administering Agencies. To achieve these objectives, BJA—

- is developing and will implement a plan to determine state compliance with DCRA requirements, including necessary documentation and metrics, and establish procedures for taking corrective action when states are out of compliance.

- will continue to provide TTA to states and provide a variety of online, virtual, and in-person resources and opportunities to improve reporting. This will include a convening in fall of 2022 with DCRA stakeholders, including State Administering Agencies and professional organizations, to continue to build awareness and support for DCRA and to share best practices regarding state-level data collection strategies.

- will continue to assess the quality and completeness of DCRA reporting, including by comparisons with open-source data (*e.g.*, media reports), and communicate these findings to State Administering Agencies in a manner that may contribute to improved reporting.

- will require FY 2022 JAG award recipients to submit state data collection plans, and BJA will assess these plans to identify opportunities for strengthening data collection practices within the states.

Proposals to Strengthen DCRA of 2013

As noted above, Congress sought to address the profoundly important issue of deaths in custody through DCRA of 2013, and the Department recognizes the importance of collecting complete and accurate data to inform strategies for reducing deaths in custody. We would like to work with Congress to improve the collection of this data. Some examples where death in custody reporting could be improved would be to—

- Permit BJS to design and implement effective methods to collect and report on comprehensive and accurate data on deaths that occur in custody.

- Eliminate the requirement for centralized state reporting, thus permitting the Department to collect information directly from state and local correctional and law enforcement agencies, open sources, and other public sources.

- Continue the current requirements for reporting by federal law enforcement agencies.

- Eliminate the requirement for quarterly reporting, allowing state and local respondents to report deaths when they have substantially all of the information on the decedent.

- Replace the current discretionary JAG grant penalty that would affect an entire state with a narrower requirement to prohibit JAG recipients from making subawards to any entity that does not certify that it will provide accurate information regarding deaths in custody that occur in its jurisdiction.

- Authorize the Department to issue additional grants and provide training or technical assistance to states, units of local government, territories, Indian Tribes, or other public or private entities to assist in the building of infrastructure or capacity for the collection and reporting of information on deaths in custody.

- Authorize NIJ to expand its research portfolio on subjects relating to deaths in custody.

- Require that BJS regularly publish comprehensive reports on deaths in custody.

- Appropriate funding for BJS and NIJ to carry out statistical collections, analysis, reporting, and research on deaths in custody.

Lastly, we wish to bring to your attention grant funding, training, and technical assistance designed to improve conditions of incarceration in state prisons, local jails, and juvenile detention facilities that OJP supports through various other programs. A list of those programs is found in Appendix C.

Thank you, again, for the opportunity to discuss this important issue, and I look forward to your questions.

Appendix A

Bureau of Justice Statistics Publications Using DCRA Data	Publication Date
Federal Deaths in Custody and During Arrest, 2020 – Statistical Tables	7/26/2022
HIV in Prisons, 2020 - Statistical Tables	5/26/2022
Mortality in State and Federal Prisons, 2001–2019 – Statistical Tables	12/1/2021
Mortality in Local Jails, 2000–2019 – Statistical Tables	12/1/2021
Suicide in Local Jails, State and Federal Prisons, 2000–2019 – Statistical Tables	10/7/2021
Federal Deaths in Custody and During Arrest, 2018–2019 - Statistical Tables	9/16/2021
Correctional Populations in the United States, 2019 - Statistical Tables	7/22/2021
Mortality In Local Jails, 2000-2018 - Statistical Tables	4/29/2021
Mortality In state And Federal Prisons, 2001-2018 - Statistical Tables	4/29/2021
Federal Deaths In Custody And During Arrest, 2016-2017 - Statistical Tables	12/29/2020
Correctional Populations In The United States, 2017-2018	8/27/2020
Mortality In Local Jails, 2000-2016 - Statistical Tables	2/12/2020
Mortality In State And Federal Prisons, 2001-2016 - Statistical Tables	2/12/2020
Arrest-Related Deaths Program: Pilot Study of Redesigned Survey Methodology	7/30/2019
Correctional Populations in the United States, 2016	4/26/2018
HIV in Prisons, 2015 - Statistical Tables	8/24/2017
Correctional Populations in the United States, 2015	12/29/2016
Arrest-Related Deaths Program Redesign Study, 2015-16: Preliminary Findings	12/15/2016
Mortality in Local Jails, 2000-2014 - Statistical Tables	12/15/2016
Mortality in state Prisons, 2001-2014 - Statistical Tables	12/15/2016
Assessing Inmate Cause of Death: Deaths in Custody Reporting Program and National Death Index	4/21/2016
Correctional Populations in the United States, 2014	12/29/2015
Assessment of Coverage in the Arrest-Related Deaths Program	10/8/2015
Mortality in Local Jails and State Prisons, 2000-2013 - Statistical Tables	8/4/2015
Arrest-Related Deaths Program: Data Quality Profile	3/3/2015
Correctional Populations in the United States, 2013	12/19/2014
Mortality in Local Jails and State Prisons, 2000-2012 - Statistical Tables	10/9/2014
Correctional Populations in the United States, 2012	12/19/2013
Mortality in Local Jails and State Prisons, 2000-2011 - Statistical Tables	8/13/2013
Mortality in Local Jails and State Prisons, 2000-2010 - Statistical Tables	12/13/2012
Correctional Populations in the United States, 2011	11/29/2012
HIV in Prisons, 2001-2010 - Revised	9/13/2012
Correctional Populations in the United States, 2010	12/15/2011
Prison and Jail Deaths in Custody, 2000-2009 - Statistical Tables	12/14/2011
Correctional Populations in the United States, 2009	12/21/2010

Deaths in Custody: Local Jail Deaths, 2000-2007- Statistical tables	10/28/2010
Deaths in Custody: State Prison Deaths, 2001-2007 - Statistical Tables	10/28/2010
Mortality in Local Jails, 2000-2007 (Revised)	7/7/2010
Deaths in Custody: State and Local Law Enforcement Arrest-Related Deaths, 2003-2006 - Statistical Tables	6/16/2009
Deaths in Custody: State Prison Deaths, 2001-2007 - Statistical Tables	10/31/2007
Medical Causes of Death in State Prisons, 2001-2004	1/21/2007
HIV in Prisons, 2004	11/19/2006
HIV in Prisons, 2003	9/1/2005
Suicide and Homicide in State Prisons and Local Jails	8/21/2005

Appendix B – DCRA Timeline

1999

May 13: The Death in Custody Reporting Act is introduced in the House of Representatives by Rep. Asa Hutchinson (R, AR-3)

2000

October 13: The Death in Custody Act of 2000 (DCRA of 2000) becomes law

Bureau of Justice Statistics (BJS) establishes Mortality in Corrections Institutions (MCI) and begins collecting mortality data from jails

2001

BJS's MCI program begins collecting mortality data from state prisons

2003

BJS begins the Arrest-Related Deaths (ARD) program, collecting data on persons who died either during the process of arrest or while in the custody of a state or local law enforcement agency

2006

DCRA of 2000 expires; BJS continues collecting MCI data

2013

April 9: The Death in Custody Act is (re)introduced in the House of Representatives

2014

December 18: The Death in Custody Act of 2013 (DCRA of 2013) becomes law

BJS suspends the ARD program due to concerns about data quality

2015

January–May (2016): ARD Assessment and Pilot Study. BJS launches a two-phase pilot study designed to test how a review of public sources could help identify the full scope of arrest-related deaths

DCRA-required reporting is supposed to be begin (collected for FY 2016)–it does not

2016

May: ARD Assessment and Pilot Study concludes

August–December: Office of Justice Programs (OJP) transfers DCRA data collection responsibility from BJS to Bureau of Justice Assistance (BJA)

August 4: BJS announces plan for DCRA collection, including mixed-method for arrest-related deaths.

December 16: The Department issues a report to Congress

December 18: Due date for DCRA Data Collection Study

December 19: BJA announces its first proposal to collect state DCRA data. BJA would require states to report data as part of JAG performance reporting instead of separate state and local agencies

2017

January–June (2018): OJP considers alternative BJA proposals

2018

June 11: BJA's Second Proposal. BJA posts a 60-day notice in the Federal Register with a revised collection plan. A significant difference between this proposal and prior proposals is that its described methodology would now require BJA to routinely validate open-source data with state reported data. Further, the new proposal substantially decreases the amount of information that state agencies must submit, which, according to OJP, would also minimize the DCRA data collection's burden on states

June–October (2019): BJA planning state DCRA data collection Plan

December: DOJ's OIG releases Review of the Department of Justice's Implementation of the Death in Custody Reporting Act of 2013.

2019

April 12: BJA's Data collection plan submitted to Office of Information and Regulatory Affairs (OIRA)

June 19: OIRA concludes review of data collection plan. Clearance is granted with approval to collect data for 2 years

October 1: BJA starts state DCRA data collection connected with the JAG performance reporting

November 14: BJA hosts a training on "Data Entry and Systems Training"

2020

BJA collects first full year of DCRA data

2021

March 31: BJS formally closes the MCI program. Last publicly available data is from 2017, however, data were collected through calendar year 2019

April: NIJ launches first of two studies to fulfill the DCRA study requirement to determine how DCRA data can be used to reduce the number of deaths in custody, and to examine whether there is any relationship between these deaths and the actions of management in jails, prisons, or other facilities

June 30: Original OMB clearance expires

September 19: DCRA data collection re-submitted to OIRA (approved for 36 months)

BJA completes arrest-related death comparison to Washington Post's Fatal Force and the Mapping Police Violence (FY 2020 ARDs)

September: NIJ launches the second of two studies to fulfill the DCRA study requirement listed above

2022

BJA completes arrest-related death comparison to FBI's Use-of-Force Data Collection program

BJA completes arrest-related death comparison to Washington Post's Fatal Force and the Mapping Police Violence (FY 2021 ARDs)

January 20: BJA hosts a "DCRA Best Practices and Reporting" training

BJA's DCRA Website complete

May 26: BJA hosts second training on "DCRA Best Practices and Reporting"

Appendix C
Mechanisms to Improve the Conditions of Incarceration

Please find a list of examples and links to their website here:

- Prison Rape Elimination Act— https://bja.ojp.gov/program/prison-rape-elimination-act-prea/overview
- Child-friendly Visiting Spaces— https://bja.ojp.gov/funding/opportunities/o-bja-2021-127001
- Corrections Training Academy Initiative— https://bja.ojp.gov/funding/awards/2019-ry-bx-k002
- COVID Detection and Mitigation in Confinement— https://bja.ojp.gov/news/now-available-guidance-detection-mitigation-covid-19-confinement-facilities
- Restrictive Housing— https://bja.ojp.gov/funding/opportunities/o-bja-2021-144001
- Body Worn Camera Program— https://bja.ojp.gov/funding/opportunities/o-bja-2022-171093
- Comprehensive Opioid, Stimulant, and Substance Abuse Program— https://bja.ojp.gov/program/cossap/overview
- Residential Substance Abuse Treatment for State Prisoners Program— https://bja.ojp.gov/program/residential-substance-abuse-treatment-state-prisoners-rsat-program/overview
- Justice and Mental Health Collaboration Program— https://bja.ojp.gov/program/justice-and-mental-health-collaboration-program-jmhcp/overview
- Crisis Stabilization and Reentry Program & Improving Adult Reentry Education and Employment Outcomes— https://bja.ojp.gov/funding/opportunities/o-bja-2022-171361
- Title II Formula Grants Program— https://ojjdp.ojp.gov/programs/formula-grants-program
- Center for Coordinated Assistance with States— https://ojjdp.ojp.gov/tta-provider/center-coordinated-assistance-states-ccas
- Juvenile Justice Emergency Planning Demonstration Program— https://ojjdp.ojp.gov/funding/opportunities/o-ojjdp-2022-171261

- Council of Juvenile Justice Administrators— https://juvenilecouncil.ojp.gov/

- Performance-based Standards— https://ojjdp.ojp.gov/tta-provider/performance-based-standards-juvenile-programs-initiative

- Initiative to Develop Juvenile Reentry Measurement Standards— https://ojjdp.ojp.gov/research-and-statistics/research-projects/initiative-develop-juvenile-reentry-measurement-standards/overview

- Second Chance Act Addressing the Needs of Incarcerated Parents and Their Minor Children— https://ojjdp.ojp.gov/funding/opportunities/o-ojjdp-2022-171233#:~:text=This%20program%20will%20provide%20funding,children%20younger%20than%20age%2018.

- Second Chance Act Youth Reentry Program— https://ojjdp.ojp.gov/funding/opportunities/o-ojjdp-2022-171233#:~:text=This%20program%20will%20provide%20funding,children%20younger%20than%20age%2018.

- Juvenile Justice System Reform Initiative— https://ojjdp.ojp.gov/funding/opportunities/o-ojjdp-2022-171358

- Reducing Risk for Girls in the Juvenile Justice System— https://ojjdp.ojp.gov/funding/opportunities/o-ojjdp-2022-171217

- National Resource Center for Justice-Involved LQBTQ+ and Two-Spirit Youth— https://ojjdp.ojp.gov/events/ojjdp-fy-2022-national-resource-center-justice-involved-lgbtq-and-two-spirit-youth

- Reducing the Use of Isolation in Juvenile Facilities— https://ojjdp.ojp.gov/funding/opportunities/ojjdp-2020-18133

- Safety, Support, and Services for Survivors of Sexual Abuse in Youth Detention— https://ovc.ojp.gov/funding/opportunities/o-ovc-2022-171240

United States Government Accountability Office

Testimony

Before the Permanent Subcommittee on Investigations, Committee on Homeland Security, and Governmental Affairs, U.S. Senate

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DEATHS IN CUSTODY

Additional Action Needed to Help Ensure Data Collected by DOJ Are Utilized

Statement of Gretta L. Goodwin, Director,
Homeland Security and Justice

GAO-22-106033

GAO Highlights

Highlights of GAO-22-106033, a testimony before the Permanent Subcommittee on Investigations, Committee on Homeland Security and Governmental Affairs, U.S. Senate

September 20, 2022

DEATHS IN CUSTODY

Additional Action Needed to Help Ensure Data Collected by DOJ Are Utilized

Why GAO Did This Study

According to DOJ, individuals incarcerated in prisons and jails are at higher risk of dying by suicide and homicide while in custody. DCRA was enacted in 2014 to encourage the study and reporting of deaths in custody. The act requires states receiving certain federal grants—as well as federal law enforcement agencies—report information on deaths in custody to the DOJ. The act also requires DOJ to study these data and report its findings to Congress.

This statement discusses (1) actions DOJ has taken to address the data collection and reporting requirements in DCRA, and (2) the extent to which DOJ has studied and used data collected from states to help reduce deaths in custody.

This statement is based on GAO's December 2021 report on DOJ's efforts to collect and publish data on law enforcement's use of force (GAO-22-104456) as well as additional audit work conducted from May 2022 through September 2022. To conduct the prior work, GAO reviewed laws and relevant DOJ documents, and interviewed DOJ officials. For the additional audit work, GAO reviewed DOJ documentation, interviewed DOJ officials, and assessed the reliability of data that DOJ collected from states.

What GAO Recommends

GAO recommends Congress consider requiring DOJ to utilize any future state data for recurring study and reporting to Congress and the public. In addition, GAO is making one recommendation to DOJ to develop an implementation plan to determine state compliance with DCRA.

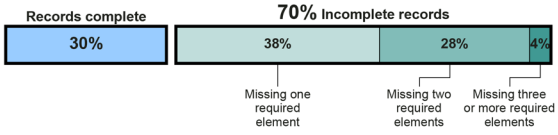
View GAO-22-106033. For more information, contact Gretta L. Goodwin at (202) 512-8777 or goodwing@gao.gov.

What GAO Found

The Department of Justice (DOJ) has taken actions to address the data collection and reporting requirements in the Death in Custody Reporting Act of 2013 (DCRA). For example, DOJ has collected and published data on deaths in federal law enforcement custody and collected similar data from states.

While states across the U.S. and DOJ have undertaken multi-year efforts to collect death in custody data, DOJ told us it has not studied these data for the purposes of addressing the study and reporting requirement in DCRA. Specifically, DOJ officials told GAO in September 2022 that they had not studied the state data, in part, because the data were incomplete. GAO compared fiscal year 2021 records that states submitted to DOJ to publicly available data and identified nearly 1,000 deaths that potentially should have been reported to DOJ but were not. Also, GAO found that 70 percent of the records provided by states were missing at least one element required by DCRA, such as a description of the circumstances surrounding the individual's death or the age of the individual (see figure).

Percentage of State Death in Custody Records That Were Complete or Missing Required Elements, Fiscal Year 2021



Source: GAO analysis of state death in custody data collected by the Department of Justice. | GAO-22-106033

DOJ has taken some steps to assess the quality of the data states submitted. However, as of August 2022, DOJ had not finished assessing the quality of the data collected from states. Further, DOJ has not developed a detailed implementation plan that includes metrics and corresponding performance targets for determining state compliance, or roles and responsibilities for taking corrective action. DOJ has previously acknowledged that determining compliance could help improve the quality of state death in custody data. Developing an implementation plan would better position DOJ to meet this goal, or take corrective actions if its current approach does not fully succeed.

Finally, even if these data were of sufficient quality, DOJ is not required by DCRA to publish state DCRA data and, as of September 2022, had no plans to do so. Absent congressional direction to help ensure that any future state data collected are utilized beyond the required study, DOJ and states may continue to use resources to compile a national dataset that may not be used to help inform practices that may reduce deaths in custody.

Chair Ossoff, Ranking Member Johnson, and Members of the Subcommittee:

I am pleased to be here today to provide insight as you examine the Department of Justice's (DOJ) efforts to help reduce the number of deaths in law enforcement custody. According to DOJ, 1.5 million individuals were incarcerated in state prisons and local jails across the U.S. at the end of 2020.[1] DOJ also has found that individuals in these facilities are at higher risk of dying by suicide and homicide.[2] National data on deaths in custody, including those that occur during the course of an arrest, have been published in the past and individual accounts continue to be reported by the media and other sources. In 2019, two juveniles—a 17-year-old and a 13-year-old—died by suicide at one youth detention center in a three-day timespan.[3] In June 2022, 25-year-old Jayland Walker was shot and killed by police during the course of an arrest in Akron, Ohio.

To encourage the study and reporting of such deaths, the Death in Custody Reporting Act of 2013 (DCRA) was enacted on December 18, 2014.[4] The act requires states that receive certain federal funding—as well as federal law enforcement agencies—to report to the Attorney General information on the deaths of individuals in the custody of state

[1]Department of Justice, Bureau of Justice Statistics, *Correctional Populations in the United States, 2020 – Statistical Tables*, (Washington, D.C.: March 2022).

[2]*Mortality in State and Federal Prisons, 2001-2019 – Statistical Tables* (Washington, D.C.: Dec. 2021), and *Mortality in Local Jails, 2001-2019 – Statistical Tables* (Washington, D.C.: Dec. 2021).

[3]Jamie Ostroff, "3 Investigates changes at Ware Youth Center following two suicides," (Shreveport, LA: KTBS, Feb, 6 2020), accessed August 3, 2022, https://www.ktbs.com/news/3investigates/3-investigates-changes-at-ware-youth-center-following-two-suicides/article_bdbc0ef2-444a-11ea-a9ee-2fc7052dac43.html.

[4]Pub. L. No. 113-242, 128 Stat. 2860 (2014).

and local law enforcement agencies.[5] The act further calls upon the Attorney General to study these data and report its findings to Congress.[6]

My statement today will focus on (1) actions DOJ has taken to address the data collection and reporting requirements in DCRA, and (2) the extent to which DOJ has studied and used the data collected from states to help reduce deaths in custody. This statement is based on findings from our December 2021 report on law enforcement's use of force, as well as additional audit work we conducted from May 2022 through September 2022.[7] For the 2021 report, we reviewed laws, congressional directives, and relevant DOJ documents, and interviewed DOJ officials. Additional information on our scope and methodology is available in that report. For the additional audit work we conducted in 2022, we reviewed DOJ documentation, including guidance DOJ developed to manage DCRA data collection from states. We also interviewed DOJ officials to further understand the department's actions to address DCRA and its use of data collected from states to help reduce deaths in custody.

We also analyzed death in custody data DOJ collected from states for fiscal year 2021.[8] We assessed the reliability of these data by analyzing the completeness of records on deaths submitted by states as of November 16, 2021. We further compared the state data to other sources of publicly available information on deaths in custody.[9] Additionally, we used *Mapping Police Violence*, a database developed by a civil rights

[5]Pub. L. No. 113-242, 128 Stat. 2860. See 34 U.S.C. § 60105 (related to state information regarding individuals who die in the custody of law enforcement). See 18 U.S.C. § 4001 note (related to the federal law enforcement death in custody reporting requirement).

[6]In particular, DCRA requires the Attorney General to carry out a study of the information reported under the act to determine means by which the information can be used to reduce the number of deaths in custody; and to examine the relationship, if any, between the number of such deaths and the actions of management of such jails, prisons, and other specified facilities relating to such deaths. See 34 U.S.C. § 60105(f).

[7]GAO, *Law Enforcement: DOJ Can Improve Publication of Use of Force Data and Oversight of Excessive Force Allegations*, GAO-22-104456 (Washington D.C.: December 7, 2021).

[8]Fiscal year 2021 was the last full year for which DOJ had collected DCRA data from states at the time we began our additional audit work.

[9]To identify deaths in prisons in fiscal year 2021, we reviewed state correctional statistical and annual reports as well as state government press releases on inmate deaths available on state government web sites. Not all states made such information available and therefore, the number of deaths we identified may be narrower than the universe of deaths that occurred in state prisons for fiscal year 2021.

organization, to identify deaths that occurred during the course of an arrest.[10] We also interviewed and obtained written responses from state officials responsible for submitting these data.[11] Our findings on the reliability of these data are discussed later in this statement. Finally, we compared DOJ's efforts to the requirements of DCRA. We also compared these efforts to standards promulgated by the Project Management Institute as well as principles found in *Standards for Internal Control in the Federal Government* related to documentation, monitoring, and corrective actions.[12]

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

DCRA generally requires the head of each federal law enforcement agency and states receiving certain federal funds to submit to the Attorney General reports that contain information regarding the death of any person who is in the custody of a law enforcement agency.[13] The

[10]"*Mapping Police Violence,*" *Campaign Zero,* accessed July 13, 2022, *https://mappingpoliceviolence.org/*. *Mapping Police Violence* is an online database that catalogs media accounts and other open-source information on incidents in which a law enforcement officer (off-duty or on-duty) uses lethal force. We limited our review of these records to incidents involving on-duty state and local law enforcement.

[11]We held telephone interviews with four randomly-selected states. We then contacted the remaining states and territories by emailing officials responsible for submitting DCRA data. We requested written responses and asked the officials about any obstacles they may have faced in collecting information on deaths in custody, and the extent to which their state submitted accurate and complete information on deaths in custody, among other things. In total, including our phone interviews, 31 of 56 state and territorial officials provided perspectives on DCRA data collection.

[12]Project Management Institute, Inc., *The Standard for Program Management – Fourth Edition (2017)*; and *A Guide to the Project Management Body of Knowledge (PMBOK® Guide) – Sixth Edition* (2017). PMBOK is a trademark of Project Management Institute, Inc. GAO, *Standards for Internal Control in the Federal Government,* GAO-14-704G (Washington, D.C.: Sept. 10, 2014).

[13]Pub. L. No. 113-242, 128 Stat. 2860.

Attorney General is also required to carry out a study of the reported information and prepare and submit to Congress a report on its findings.[14]

Federal and state data. As mentioned above, DCRA requires federal law enforcement agencies to report to DOJ data on the deaths of individuals in their custody.[15] In addition, states that receive federal grants from the Edward Byrne Memorial Justice Assistance Grant (JAG) Program are also generally required to report certain information related to the death of any person who is in the custody of a state or local law enforcement agency.[16] Reportable deaths generally include those that occurred while a person was in the process of being arrested, or incarcerated or detained at facilities such as prisons, jails, and juvenile facilities.[17] Pursuant to

[14]34 U.S.C. § 60105(f).

[15]Pub. L. No. 113-242, § 3, 128 Stat. 2860, 2861-62. See 18 U.S.C. § 4001 Note. The head of each Federal law enforcement agency shall submit to the Attorney General a report that contains information regarding the death of any person who is—"(1) detained, under arrest, or is in the process of being arrested by any officer of such Federal law enforcement agency (or by any State or local law enforcement officer while participating in and for purposes of a Federal law enforcement operation, task force, or any other Federal law enforcement capacity carried out by such Federal law enforcement agency); or (2) en route to be incarcerated or detained, or is incarcerated or detained at—(A) any facility (including any immigration or juvenile facility) pursuant to a contract with such Federal law enforcement agency; (B) any State or local government facility used by such Federal law enforcement agency; or (C) any Federal correctional facility or Federal pre-trial detention facility located within the United States."

[16]Pub. L. No. 113-242, § 2, 128 Stat. 2860, 2860-61 (codified at 34 U.S.C. § 60105). Pursuant to 34 U.S.C. § 60105, States receiving certain federal funds are to report to the Attorney General information regarding the death of any person who is detained, under arrest, or is in the process of being arrested, is en route to be incarcerated, or is 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). JAG Program grants are provided to states, territories, tribes, and local governments to support a range of criminal justice purposes. Generally, grantees can use JAG funds for a wide range of purchases and costs, including personnel, equipment, supplies, contractual support, training, technical assistance, and information systems for criminal justice. See 34 U.S.C. §§ 10151-10158. Pursuant to 34 U.S.C. § 10251(a)(2), "State" means "any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, American Samoa, Guam, and the Northern Mariana Islands."

[17]Pub. L. No. 113-242, 128 Stat. 2860. See 34 U.S.C. § 60105 (related to state information regarding individuals who die in the custody of law enforcement). See 18 U.S.C. § 4001 note (related to the federal law enforcement death in custody reporting requirement).

DCRA, the required reports from states are to contain information that, at a minimum, include:

- the gender, race, ethnicity, and age of the deceased;
- the date, time, and location of death;
- the law enforcement agency that detained, arrested, or was in the process of arresting the deceased; and
- a brief description of the circumstances surrounding the death.[18]

States that do not submit such data may receive up to a 10 percent reduction in JAG funds, at the discretion of the Attorney General.[19] Within DOJ, the Bureau of Justice Statistics (BJS) oversees the collection of the federal data, and the Bureau of Justice Assistance (BJA) oversees the collection of the state data.[20]

Study and report to Congress. DCRA also required DOJ to conduct a study on the federal and state data and submit a report on its findings to the Congress within 2 years of the enactment of the law—by December 2016. Generally, DOJ was required to carry out a study of the reported information to (1) determine means by which death in custody data can be used to reduce the number of such deaths; and (2) examine the relationship, if any, between the number of deaths and the actions of management of jails, prisons, and other specified facilities relating to such deaths.[21]

[18]34 U.S.C. § 60105(b).

[19]34 U.S.C. § 60105(c)(2).

[20]BJS, DOJ's primary statistical agency, is authorized to collect, analyze, publish, and disseminate information on crime, criminal offenders, victims of crime, and the operation of criminal justice systems at all levels of government, pursuant to 34 U.S.C. § 10132. BJA is authorized to provide grants, training and technical assistance to address criminal justice issues nationwide, pursuant to 34 U.S.C. §§ 10141-10142.

[21]Pub. L. No. 113-242, § 2, 128 Stat. 2860, 2860-61. See 34 U.S.C. § 60105(f).

DOJ Has Taken Some Steps to Address Requirements in the Death in Custody Reporting Act

Federal data collection and publication. In fiscal year 2016 (October 2015), BJS began collecting data on the deaths of individuals in the custody of federal law enforcement agencies in response to DCRA. Five years later, in December 2020, BJS began publishing reports on deaths in federal custody. As of August 2022, BJS had published reports on deaths in federal custody for fiscal years 2016 through 2020. [22] The reports include information on the number of such deaths as well as on the manner of death, weapon causing death (if applicable), and demographic information of the deceased. From fiscal years 2016 through 2020, roughly 2,700 individuals died in federal custody, according to the reports. DOJ officials said they intend to publish reports on deaths in federal custody on an ongoing basis.

State data collection. In fiscal year 2020, BJA began collecting data from states on the deaths of individuals in the custody of state and local law enforcement agencies, in response to DCRA. DCRA required states receiving JAG Program grants to report deaths in custody to DOJ beginning in fiscal year 2016. However, BJA did not begin to collect these data until 4 years later, so states did not provide death in custody reports to DOJ for fiscal years 2016 through 2019. According to the DOJ Office of Inspector General, this delay was largely due to DOJ considering—and then abandoning—three different data collection proposals from 2016 through 2018.[23] As of August 2022, BJA had collected data from states for fiscal years 2020, 2021, and the first three quarters of fiscal year 2022. According to DOJ officials, they plan to continue collecting state data in future years, as required by DCRA.

Study and report to Congress. DOJ has taken steps to address the DCRA requirement to study deaths in custody. The study and related report to Congress were due in December 2016. However, as we noted in our December 2021 report, DOJ was not positioned to conduct the study until DCRA data collection efforts were underway. Our 2021 report also noted that DOJ awarded a contract to a consultant in March 2021 to

[22]Bureau of Justice Statistics, *Federal Deaths in Custody and During Arrest, 2016-2017 - Statistical Tables,* (Washington, D.C.: December 2020); *Federal Deaths in Custody and During Arrest, 2018-2019 - Statistical Tables,* (Washington, D.C.: March 2021); *Federal Deaths in Custody and During Arrest, 2020 - Statistical Tables,* (Washington, D.C.: July 2022).

[23]For more information, see Department of Justice, Office of Inspector General, *Review of the Department of Justice's Implementation of the Death in Custody Reporting Act of 2013,* (Washington, D.C.: December 2018).

complete the first part of the DCRA study requirement—that is, determine means by which death in custody data collected under DCRA can be used to reduce the number of such deaths.[24] In September 2022, DOJ officials told us the consultant had produced a draft report, which considered federal DCRA data. Officials said the department was finalizing the report and planned to submit it to Congress by December 2022. The extent to which the study and report will use state DCRA data is discussed later in this statement.

DOJ awarded a contract to a consultant in September 2021 to address the second part of the study requirement—to examine the relationship, if any, between the number of deaths and the actions of management of jails, prisons, and other specified facilities relating to such deaths.[25] DOJ expects this part of the study to be complete in 2024 and plans to submit the related findings to Congress thereafter.

DOJ Has Not Studied State Death in Custody Data or Determined States' Compliance with DCRA

While states across the U.S. and DOJ have undertaken multi-year efforts to gather death in custody data, the department has not yet studied the state data, for purposes of the report required by DCRA. DOJ officials told us in September 2022 that they had not studied the data to determine the means by which the information could be used to reduce deaths in custody, in part, because the data provided by states were incomplete or missing.[26] By law, the Attorney General may impose a penalty on states that fail to comply with DCRA reporting requirements (i.e., do not provide data on deaths in custody as required).[27] However, DOJ's efforts to determine states' compliance with DCRA have been delayed and DOJ has not yet made such determinations. In addition, even if these data were of sufficient quality, DOJ officials indicated the department is not required to publish these data pursuant to DCRA and, as of September 2022, has no plans to do so.

[24]See 34 U.S.C. § 60105(f)(1)(A).

[25]See 34 U.S.C. § 60105(f)(1)(B).

[26]DOJ officials noted that they had begun to assess the quality of the state data submission, which we discuss below.

[27]34 U.S.C. § 60105(c)(2).

DOJ Has Not Studied State Death in Custody Data Because the Data Are Incomplete

DOJ has taken steps to address the study and report required by DCRA. However, DOJ officials told us the consultant did not analyze the state DCRA data as part of the first report—despite that being a requirement of the law—because the data were incomplete. Instead, DOJ instructed the consultant to use other, older state and local data collected by BJS to meet the DCRA study and report requirements.[28] In addition, DOJ officials have not committed to using the state DCRA data as part of its second report to address DCRA.[29]

In June 2019, the Office of Management and Budget tasked BJS with reviewing the quality of state death in custody data collected by BJA for DCRA.[30] In response, BJS completed a review of state death in custody data for the first quarter of fiscal year 2020. BJS characterized the state data as having a high rate of incomplete records. In particular, BJS noted that a description of the death was missing from 24 percent of records; a cause of death was missing from 14 percent of records and the individual's year of birth was missing from 6 percent of records. In addition, BJS found that a number of deaths had not been reported at all. Specifically, the DCRA data collected from states did not capture any deaths in state prisons for 11 states or deaths in local jails for 12 states, despite evidence that such deaths occurred while individuals were in custody. BJS noted that these issues limited the statistical analyses that could be performed with the data.

[28]DOJ instructed the consultant to focus the analysis on BJS collections including the Mortality in Correctional Institutions program and the Arrest Related Deaths program. BJS last published statistics from the Mortality in Correctional Institutions program for calendar year 2019, and last published statistics from the Arrest-Related Deaths Program for calendar year 2012.

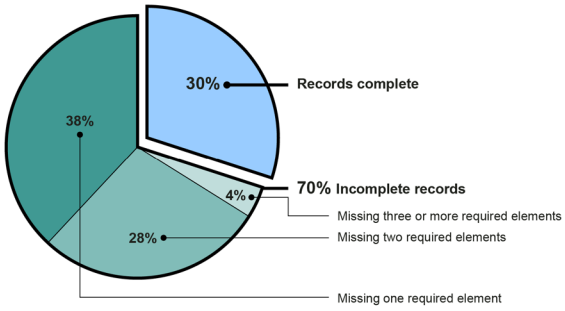
[29]The scope of work agreed to with the consultant for the second study states that the consultant may use these data but does not require it. DOJ officials told us they continue to consider the suitability of these data to meet the second reporting requirement but have not made a determination as of August 2022.

[30]Specifically, the Office of Management and Budget tasked BJS with studying the quality of death in custody data collected by BJA and the potential overlap between the DCRA and Mortality in Corrections program data.

We analyzed data that DOJ collected from states in fiscal year 2021 and found many of the same issues observed by BJS in the prior year's collection.[31] Below is a summary of our findings.

Incomplete records. We found that 70 percent of records on deaths in custody provided by states in fiscal year 2021 were missing at least one element required by law.[32] For example, roughly 40 percent of the records states provided on deaths in custody did not include a description of the circumstances surrounding the death. In addition, 32 percent of records were missing more than one element, see figure 1.

Figure 1: Percentage of State Death in Custody Records That Were Complete or Missing Required Elements, Fiscal Year 2021



Source: GAO analysis of state death in custody data collected by the Department of Justice. | GAO-22-106033

Note: We analyzed fiscal year 2021 data the Department of Justice collected from states in response to the Death in Custody Reporting Act, as of November 16, 2021. Required elements include biographical information on the deceased, as well as the date, time, and location of death; the law enforcement agency that detained, arrested, or was in the process of arresting the deceased; and a brief description of the circumstances surrounding the death.

[31]We analyzed the data as of November 16, 2021. According to DOJ officials, states can update the data previously provided, and thus, the data can change over time.

[32]As discussed earlier, states are required to report certain biographical information on the deceased, as well as the date, time, and location of death; the law enforcement agency that detained, arrested, or was in the process of arresting the deceased; and a brief description of the circumstances surrounding the death. 34 U.S.C. § 60105(b).

Most state submissions contained incomplete records. Of the 47 states that submitted data, we found that two states had provided 100 percent of records with all the required elements. In contrast, seven states did not report any records with all of the required elements. State officials we spoke with provided reasons that they may submit incomplete records. For example, a state or local law enforcement agency may not provide all required information to the state officials responsible for reporting death in custody data to DOJ. In addition, investigations into deaths may be ongoing, and therefore not all information about a death in custody will be available at the time state officials report the data to DOJ.

Unreported deaths. Some states did not accurately account for all deaths in custody that occurred in fiscal year 2021. By reviewing documentation available on state government web sites and public databases on arrest-related deaths, we identified nearly 1,000 deaths that occurred during fiscal year 2021 that states did not report in response to DCRA.[33] For example, four states that accepted JAG awards did not report any deaths in custody in their state—even though reporting this information is a requirement of receiving the grant funding and deaths occurred in their state during this time period.[34]

[33]We identified 341 deaths that occurred in prisons in seven states that were potentially reportable to DOJ as part of DCRA but were not reported. Not all states made data on deaths in correctional facilities available at the time we conducted our audit work and therefore, we were unable to test the completeness of all states' submissions. As a result, the number of prison deaths we identified may be narrower than the universe of prison deaths not reported to DOJ for fiscal year 2021. We are relying on states' disclosures of deaths in custody and did not independently verify that these deaths occurred in custody and therefore refer to these deaths as potentially reportable. Additionally, we used the *Mapping Police Violence* database to identify deaths that occurred during the course of an arrest and identified 649 arrest-related deaths that were not reported as part of DCRA. *Mapping Police Violence* uses media accounts and other open-source information to collect information on deaths. Therefore, if an arrest-related death was not made public, it would not be included in this database and we could not determine if it was captured in DCRA data or not. As a result, the number of arrest-related deaths we identified may be narrower than the universe of arrest-related deaths not reported to DOJ.

[34]In particular, 56 states accepted JAG awards for fiscal year 2021 and 47 states reported deaths in custody to DOJ. Of the nine states that did not report any deaths in custody for fiscal year 2021, we were able to identify 124 deaths in custody in four of those states. As noted earlier, we are including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, American Samoa, Guam, and the Northern Mariana Islands as states consistent with 34 U.S.C. § 10251(a)(2).

DOJ Has Not Determined Whether States Complied with the Death in Custody Reporting Act

DOJ officials noted that they have taken some steps to assist states in reporting deaths in custody data. For example, DOJ officials told us it held training webinars on DCRA with states officials responsible for submitting the data. In addition, DOJ officials told us they reviewed the results of a survey of state officials responsible for submitting DCRA data to better understand the challenges associated with the program.

However, DOJ has not determined whether states have complied with DCRA. Specifically, DOJ guidance outlines how it will determine states' compliance with DCRA and DOJ officials have begun to assess the quality of the state data, as an initial step towards determining compliance. However, these assessments have been delayed and are not finalized for fiscal years 2020 and 2021. As a result, DOJ officials have not yet determined whether states complied with DCRA for these fiscal years.

DOJ developed internal guidance—the DCRA Procedures and Methods document—to manage data collection from states. Among other things, this documentation outlines how staff are to assess the quality of state death in custody data and ultimately determine state compliance with DCRA. The document outlines compliance scenarios such as:

- DOJ will consider states that report complete and accurate information on deaths in custody as compliant with DCRA.
- States that report incomplete data will be considered compliant with DCRA if the state makes a 'good faith effort' to obtain and report the missing data after being alerted by DOJ about data issues.

DOJ officials told us they have begun efforts to assess the quality of the state data. For instance, DOJ reviewed state data to identify missing elements. In addition, the department compared data provided by states to publicly available databases on deaths in custody and therefore have some awareness of when states have under-reported deaths in custody.[35]

However, DOJ efforts to finalize these data quality assessments and determine compliance have been delayed multiple times. Thus, DOJ has not communicated to states whether they have complied with DCRA. In a 2016 report to Congress on the implementation of DCRA, DOJ said it had

[35]These include the FBI's Use of Force Database as well as non-governmental efforts, such as the Washington Post's database on fatal force used by law enforcement and the *Mapping Police Violence* database.

planned to determine state compliance with DCRA in February 2019 based upon data collected for fiscal year 2018. However, as previously discussed, DOJ did not begin collecting data until fiscal year 2020, and thus was not positioned to make compliance determinations for fiscal years 2018 and 2019. As described in our December 2021 report, DOJ officials told us that they had begun to assess the quality of the fiscal year 2020 state data and planned to complete a review of these data by October 2021.[36] However, when we followed up with DOJ in July 2022, agency officials said they had not finalized the review. DOJ officials told us they plan to complete the assessment by October 2022. DOJ officials also said they had not completed an assessment of fiscal year 2021 data.

Consensus-based standards for program and project management, such as those disseminated by the Project Management Institute, indicate that once implementation efforts are underway, organizations should oversee those efforts on an ongoing basis to ensure their consistent execution.[37] Those standards further indicate that organizations should document roles and responsibilities, the metrics they will use to assess their implementation efforts, and the performance targets against which those metrics are measured to determine success.[38] Similarly, *Standards for Internal Control in the Federal Government* states that agencies should document policies and procedures for program management and oversight, monitor program performance and progress, ensure that corrective actions are identified and assigned to the appropriate parties on a timely basis, and ensure that corrective actions are tracked until the desired outcomes are achieved.[39]

DOJ has developed a framework for determining states' compliance. However, it has not developed a detailed implementation plan that includes metrics and corresponding performance targets for determining state compliance, or roles and responsibilities for taking corrective action should these efforts not fully succeed. Specifically, DOJ documentation identifies criteria for determining compliance and actions it could take to increase compliance. However, DOJ does not have specific metrics and

[36]GAO-21-104456.

[37]Project Management Institute, Inc., *The Standard for Program Management – Fourth Edition (2017)*.

[38]Project Management Institute, Inc., A Guide to the Project Management Body of Knowledge (PMBOK® Guide) – Sixth Edition (2017).

[39]GAO-14-704G.

performance targets on, for example, the number of states it expects to achieve full compliance, or by when it expects this to occur. Further, DOJ has not identified roles and responsibilities for taking corrective actions.

DOJ has previously acknowledged that determining compliance could help improve the quality of state DCRA data. In its 2016 report to Congress, DOJ noted that possible short-comings of state DCRA data could be mitigated by, among other efforts, determining compliance and has also noted its goal to help ensure states comply with DCRA. Until DOJ completes its assessments, states will have limited information about whether they are complying with DCRA and whether they will be potentially subject to a penalty. Further, states may be unaware of the full extent of data quality issues within their submissions, and thus, fail to take action to correct the submissions.[40] Developing an implementation plan that includes documentation of metrics and corresponding performance targets, and identifies roles and responsibilities for taking corrective action, would better position DOJ to support states in achieving compliance, or take corrective actions as needed.

DOJ Is Not Required to Publish State Death in Custody Data and Has No Plans to Do So

DCRA requires the ongoing collection of state death in custody data, as discussed earlier. However, DCRA does not require publication of these data, and as of September 2022, officials told us they had no current plans to do so. As such, in future years, DOJ and states may use their respective resources to continue collecting data without plans for DOJ to publish or otherwise use the data to inform practices to help reduce deaths in custody.

DCRA does not require the publication of state data collected under the act. Further, DOJ officials stated that they could only publish such data if two conditions were met pursuant to 34 U.S.C. § 10231(a). According to 34 U.S.C. § 10231(a), generally, no officer or employee of the federal government, and no recipient of assistance of certain federal funds shall use or reveal any research or statistical information furnished by any person and identifiable to any specific private person for any purpose other than the purpose for which it was obtained. Therefore, DOJ stated that the following two conditions need to be met to publish information related to the collected data under DCRA. First, to publish any research or statistical information collected under DCRA, the information could not be identifiable to any specific private person, which includes information

[40]DOJ officials told us that states may continuously update their data even after the reporting period has passed.

identifiable to a private person that either is "labelled by name or other personal identifiers" or could "by virtue of sample size or other factors, be reasonably interpreted as referring to a particular private person." Second, information collected under DCRA would need to be published for the purpose of enabling the Attorney General's statutorily authorized study of that information to "determine means by which such information can be used to reduce the number of such deaths" and "examine the relationship, if any, between the number of such deaths and the actions of management of such jails, prisons, and other specified facilities related to such deaths."

However, as noted earlier, DOJ officials told us they did not use state DCRA data as part of its first report and have not committed to using the state DCRA data as part of its second report to address the DCRA study requirement. In addition, DOJ is not required to conduct any additional studies of the state data, and had no current plans to conduct more studies as of September 2022.

Importantly, after DOJ's DCRA data collection efforts began, it discontinued a long-standing program that collected and published data on deaths of individuals in state and local correctional institutions, the Mortality in Correctional Institutions program.[41] In the past, DOJ has used data collected by this program to publish reports and statistical information on deaths in correctional institutions. The published information allowed Congress, researchers, and others in the public to view and study the data to help address such deaths. However, after DOJ began collecting DCRA data from states, it halted the Mortality in Correctional Institutions program and thus stopped publishing the data. However, whereas Mortality in Correctional Institutions resulted in ongoing data available to the public, DCRA may not.

In the House committee report accompanying DCRA, the committee noted that state and local death in custody statistics previously collected by DOJ represent a unique national resource for understanding mortality

[41]This program, which was initiated in 2000, annually collected data on individuals who died in custody from 50 state departments of corrections, approximately 2,800 local jail jurisdictions, and the Bureau of Prisons. Specifically, the data that BJS collected through Mortality in Correctional Institutions included deceased individuals' demographic characteristics and criminal background (i.e., legal status, offense type, and time served). BJS also collected data on the circumstances surrounding individuals' deaths, including the date, time, location, and cause of death, as well as information on the autopsy and medical treatment provided.

in the criminal justice system.[42] Further, some state representatives we spoke with noted that their states have limited staff and resources, but had nonetheless invested in training and developing systems to report the death in custody data to DOJ. DOJ officials responsible for the program also noted that their office had finite resources with which to manage the DCRA program. Absent congressional direction to help ensure that any future state data collected under the act are utilized for recurring study and reporting to Congress and the public, DOJ and states may continue to use resources to compile a national dataset that may not be used to help inform practices to reduce deaths in custody.

Conclusions

In the intervening eight years since DCRA was enacted in 2014, DOJ has made some progress toward addressing what it has called a profoundly important issue, but significant work remains. DOJ has begun collecting and publishing data on deaths in federal custody and began collecting data from states. However, it has not finalized assessments regarding the quality of state data and as a result, has not determined whether states are complying with DCRA data requirements. Developing an implementation plan could better position DOJ to determine whether current efforts to achieve states' compliance with DCRA have been successful or need modification. In addition, DOJ is not required to publish state data collected under DCRA and has no current plans to do so. Absent Congressional action, states and DOJ may continue to expend resources to gather data under DCRA that may not be studied or published, potentially missing an opportunity to inform practices to help reduce deaths in custody.

Matter for Congressional Consideration

Congress should consider the extent to which DCRA should be amended to help ensure that any future state data provided under the act are utilized for recurring study and reporting by DOJ to Congress and the public. (Matter for Consideration 1)

Recommendation for Executive Action

The Assistant Attorney General for the Office of Justice Programs should develop a DOJ implementation plan—that includes documentation of metrics and corresponding performance targets, and identifies roles and responsibilities for taking corrective action—to determine state compliance with DCRA. (Recommendation 1)

Agency Comments

[42]H.R. Rep. No. 113-285 (2013).

We requested comments on the contents of this statement, including our recommendations, from DOJ. The department provided technical comments, which we incorporated as appropriate.

Chair Ossoff, Ranking Member Johnson, and Members of the Subcommittee, this concludes my prepared remarks. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgements

If you or your staff have any questions about this testimony, please contact Gretta L. Goodwin, Director, Homeland Security and Justice at (202) 512-8777 or GoodwinG@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report.

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United States Senate
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
Committee on Homeland Security and Governmental Affairs

Jon Ossoff, Chair
Ron Johnson, Ranking Member

UNCOUNTED DEATHS IN AMERICA'S PRISONS & JAILS: HOW THE DEPARTMENT OF JUSTICE FAILED TO IMPLEMENT THE DEATH IN CUSTODY REPORTING ACT

STAFF REPORT

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

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Table of Contents

Uncounted Deaths in America's Prisons & Jails: How the Department of Justice Failed to Implement the Death in Custody Reporting Act

Executive Summary

Approximately 1.5 million people are incarcerated in state and local correctional facilities throughout the United States.[1] Thousands die every year.[2] The Death in Custody Reporting Act of 2013 ("DCRA 2013" or "the reauthorization")—reauthorizing a law that first passed in 2000—requires states that accept certain federal funding to report to the Department of Justice ("DOJ" or "the Department") about who is dying in prisons and jails.[3]

Over the course of a ten-month bipartisan investigation into DOJ's implementation of the law, the Permanent Subcommittee on Investigations ("PSI" or "the Subcommittee") found that DOJ is failing to effectively implement DCRA 2013. DOJ's failed implementation of DCRA 2013 undermined the effective, comprehensive, and accurate collection of custodial death data.

This failure in turn undermined transparency and Congressional oversight of deaths in custody. The Subcommittee has found that DOJ will be at least eight years past-due in providing Congress with the DCRA 2013-required 2016 report on how custodial deaths can be reduced. The Subcommittee also highlights the following key facts: in Fiscal Year ("FY") 2021 alone, DOJ failed to identify at least 990 prison and arrest related deaths; and 70% of the data DOJ collected was incomplete.[4] DOJ failed to implement effective data collection methodology, despite internal warnings from the DOJ Office of the Inspector General ("OIG") and the Bureau of Justice Statistics (BJS).[5] DOJ's failures were preventable.

* * *

[1] Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 1 (GAO-22-106033) (Sept. 20, 2022).

[2] In FY 2019, for example, a total of 3,853 individuals died in state prisons or private prison facilities under a state contract and a total of 1,200 individuals died in local jails. *See* Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in State and Federal Prisons 2001-2019—Statistical Tables* (Dec. 2021) (bjs.ojp.gov/content/pub/pdf/msfp0119st.pdf); Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in Local Jails 2000-2019—Statistical Tables* (Dec. 2021) (bjs.ojp.gov/content/pub/pdf/mlj0019st.pdf).

[3] Death in Custody Reporting Act of 2013, Pub. L. No. 113-242; Death in Custody Reporting Act of 2000, Pub. L. No. 106-297. DCRA 2013, which became law in 2014, requires federal agencies to report deaths in custody to DOJ. *Id.* This report and investigation focuses on the portion of DCRA 2013 that concerns deaths in state or local custody, and does not consider the portion of the law that concerns deaths in federal custody.

[4] Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 1 (GAO-22-106033) (Sept. 20, 2022).

[5] Dr. E. Ann Carson, Bureau of Justice Statistics, *Report Comparing Bureau of Justice Statistics and Bureau of Justice Assistance Mortality Death Collections, to fulfill Terms of Clearance for OMB Control Number 1121-0249* (May 11, 2021) (omb.report/icr/202105-1121-001/doc/111526800); Department of Justice, Office of the Inspector General, *Review of the Department of Justice's Implementation of the Death in Custody Reporting Act of* 2013 (Dec. 2018) (oig.justice.gov/reports/2018/e1901.pdf).

The co-sponsors of DCRA, which passed the United States Senate by unanimous consent and the United States House of Representatives by wide bipartisan margins in both 2000 and again in 2013, described why collecting death data was critical: it would bring a "new level of accountability to our Nation's correctional institutions"; "provide openness in government"; "bolster public confidence and trust in our judicial system"; and "bring additional transparency."[6]

DOJ itself described the law in similar terms. According to DOJ:

> The requirements set forth in DCRA provide an opportunity to improve understanding of why deaths occur in custody and develop solutions to prevent avoidable deaths. Knowledge of the circumstances leading to death and the number of fatalities is crucial to developing policies and program changes that could reduce the number of deaths in custody.[7]

DCRA 2013 requires "at a minimum" that states report to DOJ the following information about custodial deaths: the name, gender, race, ethnicity, and age of the deceased; the date, time, and location of death; the law enforcement agency that was holding the decedent; and a brief description of the circumstances surrounding the death.[8] DCRA 2013 also requires DOJ to report to Congress on how that information can be used to prevent avoidable deaths.[9] This report was due on December 18, 2016, two years after DCRA 2013 became law.[10]

DOJ's efforts to implement DCRA 2013 were a continuation of its efforts to implement the original version of the law, the Death in Custody Reporting Act of 2000 ("DCRA 2000").[11] In response to DCRA 2000, DOJ tasked its criminal justice statistics agency, BJS, with creating a national survey of deaths in federal, state, and local custody.[12] From 2000 through 2019, BJS collected, studied, and made public information about deaths in custody, information that went

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[6] Statement of Representative Asa Hutchinson, Congressional Record, H6737 (July 24, 2000); Statement of Senator Patrick Leahy, Congressional Record, S6341 (Dec. 4, 2014).
[7] Department of Justice, Bureau of Justice Assistance, Death in Custody Reporting Act (DCRA) Data Collection (bja.ojp.gov/program/dcra/overview).
[8] Death in Custody Reporting Act of 2013, Pub. L. No. 113-242.
[9] Death in Custody Reporting Act of 2013, Pub. L. No. 113-242.
[10] Death in Custody Reporting Act of 2013, Pub. L. No. 113-242.
[11] Death in Custody Reporting Act of 2000, Pub. L. No. 106-297. DCRA 2000 required DOJ to collect almost all of the same information as required under DCRA 2013. Specifically, the law required that the information collected "at a minimum" includes: (1) the name, gender, race, ethnicity, and age of the deceased; (2) the date, time, and location of death; and (3) a brief description of the circumstances surrounding the death. *Id.* Unlike DCRA 2013, DCRA 2000 did not require the collection of "the law enforcement agency that detained, arrested, or was in the process of arresting the deceased."
[12] Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in Correctional Institutions (MCI) (Formerly Deaths in Custody Reporting Program (DCRP)* (bjs.ojp.gov/data-collection/mortality-correctional-institutions-mci-formerly-deaths-custody-reporting-program).

far beyond the statutory requirements.[13] During this period, BJS claims to have collected data from an average of 98% of all local jails and 100% of all state prisons.[14]

In a change from DCRA 2000, DCRA 2013 authorizes the Attorney General to withhold up to 10% of Edward Byrne Memorial Justice Assistance Grant ("JAG") funding from states that accepted those funds but did not report custodial death data to DOJ.[15] In 2016, two years after DCRA 2013 became law, DOJ decided that BJS could no longer implement DCRA 2013.[16] DOJ explained its rationale in a December 2016 report to Congress.[17] According to DOJ, because BJS was a statistical agency, it was precluded from administering a data collection program with "compliance and penalty determinations," such as the penalty included in DCRA 2013.[18] DOJ informed Congress that it would be reassigning the state death data collection from BJS to the Bureau of Justice Assistance ("BJA"), a grant-making agency within DOJ's Office of Justice Programs ("OJP").[19]

However, BJS had already been collecting, studying, and reporting on state and local death data for sixteen years.[20] BJS continued to collect state and local custodial death data until BJA finally began its collection in FY 2020.[21]

Since the transfer of data collection responsibility to BJA, DOJ has not publicly reported on any data that BJA has collected.[22] Additionally, DOJ is not expected to complete the

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[13] Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in Correctional Institutions (MCI) (Formerly Deaths in Custody Reporting Program (DCRP)* (bjs.ojp.gov/data-collection/mortality-correctional-institutions-mci-formerly-deaths-custody-reporting-program).

[14] Dr. E. Ann Carson, Bureau of Justice Statistics, *Report Comparing Bureau of Justice Statistics and Bureau of Justice Assistance Mortality Death Collections, to fulfill Terms of Clearance for OMB Control Number 1121-0249*, at 3 (May 11, 2021) (omb.report/icr/202105-1121-001/doc/111526800).

[15] Department of Justice, *Report of the Attorney General to Congress Pursuant to the Death in Custody Reporting Act*, at 5 (Dec. 16, 2016) (www.justice.gov/archives/page/file/918846/download).

[16] *See* Department of Justice, *Report of the Attorney General to Congress Pursuant to the Death in Custody Reporting Act* (Dec. 16, 2016) (www.justice.gov/archives/page/file/918846/download).

[17] Department of Justice, *Report of the Attorney General to Congress Pursuant to the Death in Custody Reporting Act* (Dec. 16, 2016) (www.justice.gov/archives/page/file/918846/download).

[18] Department of Justice, *Report of the Attorney General to Congress Pursuant to the Death in Custody Reporting Act*, at 8 n.17 (Dec. 16, 2016) (www.justice.gov/archives/page/file/918846/download); Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022).

[19] Department of Justice, *Report of the Attorney General to Congress Pursuant to the Death in Custody Reporting Act*, at 8 n.17 (Dec. 16, 2016) (www.justice.gov/archives/page/file/918846/download). Federal data collection remained with BJS however, because there was no penalty associated with federal data collection. *See* Death in Custody Reporting Act of 2013, Pub. L. No. 113-242.

[20] Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022); Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in Correctional Institutions (MCI) (Formerly Deaths in Custody Reporting Program (DCRP)* (bjs.ojp.gov/data-collection/mortality-correctional-institutions-mci-formerly-deaths-custody-reporting-program).

[21] Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in Correctional Institutions (MCI) (Formerly Deaths in Custody Reporting Program (DCRP)* (bjs.ojp.gov/data-collection/mortality-correctional-institutions-mci-formerly-deaths-custody-reporting-program).

[22] *See* Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022). DOJ is not required to make public DCRA data under the statute. Death in Custody Reporting Act of 2013, Pub. L. No. 113-242.

statutorily required report to Congress before September 2024, at least eight years past due.[23] DOJ also has no plans to make public any further state and local death information.[24]

In December 2021, PSI began a ten-month bipartisan investigation into DOJ's efforts to implement DCRA 2013, and, specifically, BJA's efforts to collect and report on state and local custodial deaths.[25] During the course of this investigation, PSI interviewed a DOJ official who spoke on behalf of the agency, family members of ten people who died in state or local custody across the country, and two criminal justice experts to assess how DCRA data can be used to bring transparency to custodial deaths.[26] On March 23, 2022, PSI requested that the Government Accountability Office ("GAO") analyze data that BJA had collected for FY 2021 pursuant to DCRA 2013.[27] Based on a review of public and non-public information, including GAO's analysis, the Subcommittee found that DOJ has failed to implement DCRA 2013.

The Subcommittee notes that DOJ failed to provide full and complete information to the Subcommittee.[28] DOJ's resistance to bipartisan Congressional oversight impeded Congress' ability to understand whether DCRA 2013 had been properly implemented, delaying potential reforms that could restore the integrity of this critical program.

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[23] Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022); Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 7 (GAO-22-106033) (Sept. 20, 2022).

[24] Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022).

[25] The Subcommittee did not evaluate DOJ's efforts to comply with the section of DCRA 2013 concerning federal agencies' reporting of deaths in custody, which is administered by BJS and appears to be proceeding pursuant to the requirements of the law.

[26] Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022); University of California Los Angeles School of Law Carceral Mortality Project, Briefing with Senate Permanent Subcommittee on Investigations (Aug. 3, 2022); Shanelle Jenkins, Interview with Senate Permanent Subcommittee on Investigations (May 31, 2022); Sandy Ray, Interview with Senate Permanent Subcommittee on Investigations (May 25, 2022); Dawn Reid, Interview with Senate Permanent Subcommittee on Investigations (May 9, 2022); Melania Brown, Interview with Senate Permanent Subcommittee on Investigations (May 9, 2022); Glenda Hester, Interview with Senate Permanent Subcommittee on Investigations (May 6, 2022); Belinda Maley, Interview with Senate Permanent Subcommittee on Investigations (May 4, 2022); Sherilyn Sabo, Interview with Senate Permanent Subcommittee on Investigations (Apr. 22, 2022); Vanessa Fano, Interview with Senate Permanent Subcommittee on Investigations (Apr. 20, 2022); Linda Franks, Interview with Senate Permanent Subcommittee on Investigations (Apr. 14, 2022); Jennifer Bradley, Interview with Senate Permanent Subcommittee on Investigations (Apr. 19, 2022); Professor Andrea Armstrong, Loyola University New Orleans School of Law, Briefing with Senate Permanent Subcommittee on Investigations (Apr. 19, 2022).

[27] Letter from Chair Jon Ossoff, Senate Permanent Subcommittee on Investigations, to Government Accountability Office (Mar. 23, 2022); U.S. Government Accountability Office, About Page (www.gao.gov/about) (accessed Sept. 19, 2022).

[28] Letter from Senate Permanent Subcommittee on Investigations to Department of Justice (Dec. 3, 2021); Letter from Department of Justice to Senate Permanent Subcommittee on Investigations (Feb. 11, 2022); Letter from Senate Permanent Subcommittee on Investigations to Department of Justice (Apr. 27, 2022). DOJ provided only a single interview to the Subcommittee and provide only aggregate death data from six states over two-years.

Key Facts:

1. **Nearly One Thousand Missing Deaths.** As part of its review for PSI, GAO identified at least 990 deaths that were potentially reportable to BJA in FY 2021, but that BJA had not counted.[29] Of the 990 uncounted deaths, 341 were prison deaths disclosed on states' public websites and 649 were arrest-related deaths disclosed in a reliable, public database.[30] GAO determined that BJA's collection was missing information that is already in the public domain.[31]

2. **Incomplete Data.** GAO found that for FY 2021, the vast majority of death in custody information that BJA collected from the states was incomplete.[32] Specifically, 70% of records on deaths in custody were missing at least one DCRA 2013-required data field; approximately 40% of the records did not include a description of the circumstances surrounding the death; and 32% of the records were missing more than one DCRA 2013-required data field.[33]

3. **Failure to Report.** DCRA 2013 required DOJ to report to Congress by December 18, 2016 on how the data it collected can be used "to reduce the number of such deaths" and to "examine the relationship, if any, between the number of such deaths and the actions of management of such jails, prisons, and other specified facilities relating to such deaths."[34] DOJ does not expect to complete these reporting requirements before September 2024—eight years late.[35] DOJ has not yet evaluated whether the data that it had collected in FY 2020 or FY 2021 is of sufficient quality to be used in the DCRA 2013-required analysis and report to Congress.[36]

4. **Failed Transition.** DOJ failed to properly manage the transition of DCRA 2013 data collection from BJS to BJA. BJA's failure to properly collect and report on custodial death data stands in marked contrast to BJS's successful efforts to do these same things for 20 years. To the extent that DOJ sought to assign DCRA 2013 responsibilities to

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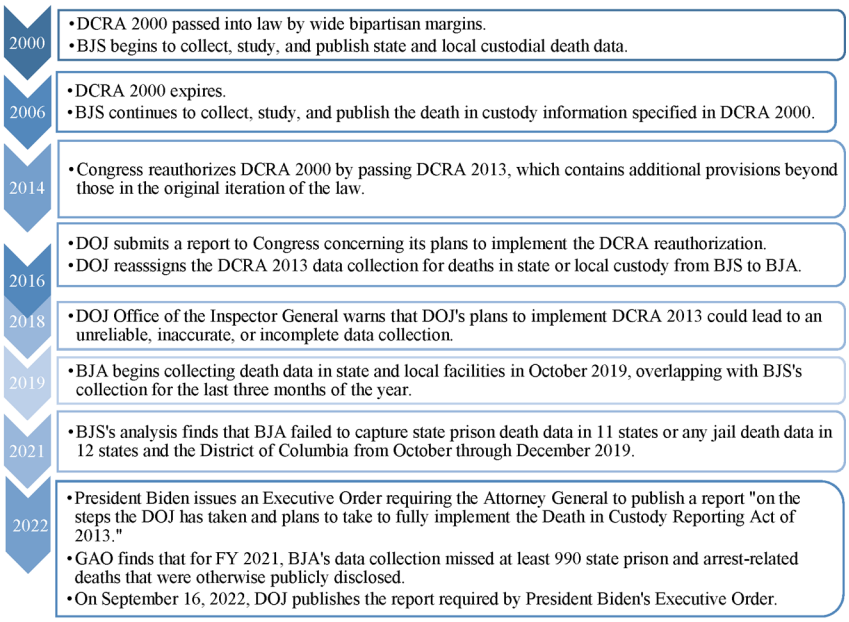
[29] Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 10 n.33 (GAO-22-106033) (Sept. 20, 2022).
[30] Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 10 n.33 (GAO-22-106033) (Sept. 20, 2022).
[31] Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 10 (GAO-22-106033) (Sept. 20, 2022).
[32] Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 9 (GAO-22-106033) (Sept. 20, 2022).
[33] Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 9 (GAO-22-106033) (Sept. 20, 2022).
[34] Death in Custody Reporting Act of 2013, Pub. L. No. 113-242.
[35] Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022).
[36] Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022).

BJA, it should have done more to equip it with the resources and strategies it already knew to be successful so that DOJ could meet its statutory obligations.[37]

DOJ's failure to implement DCRA has deprived Congress and the American public of information about who is dying in custody and why. This information is critical to improve transparency in prisons and jails, identifying trends in custodial deaths that may warrant corrective action—such as failure to provide adequate medical care, mental health services, or safeguard prisoners from violence—and identifying specific facilities with outlying death rates. DOJ's failure to implement this law and to continue to voluntarily publish this information is a missed opportunity to prevent avoidable deaths.

[37] Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022). The Subcommittee further notes that DOJ's rationale for reassigning the state death data collection from BJS—a statistical agency that had successfully collected and published DCRA data for 20 years—to BJA—a grant-making agency with no track record of collecting or reporting on similar data—was that the DCRA 2013 JAG penalty precluded BJS's administration of the program. Department of Justice, *Report of the Attorney General to Congress Pursuant to the Death in Custody Reporting Act* (Dec. 16, 2016) (www.justice.gov/archives/page/file/918846/download). Yet, DOJ's decision came two years after BJS had already been collecting state death data pursuant to DCRA 2013, and DOJ permitted BJS to continue its collection for another three years. Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022).

Figure 1: Death in Custody Reporting Act Timeline



I. The Death in Custody Reporting Act

a. History

In 2000, Congress passed DCRA 2000, which required states to issue quarterly reports to the Attorney General about prison and jail deaths.[38] In order to be eligible for Violent Offender Incarceration and Truth in Sentencing grant funding—funding for building or expanding correctional facilities—states were required to "provide assurances" that they will report data to DOJ for the following fields: (1) the name, gender, race, ethnicity, and age of the deceased; (2) the date, time, and location of death; and (3) a brief description of the circumstances surrounding death.[39]

In response to the passage of DCRA 2000, BJS, DOJ's statistical agency, established a national custodial death data collection.[40] BJS began collecting individual death records from local jails in 2000 and state prisons in 2001 as part of a national study that came to be known as Mortality in Correctional Institutions ("MCI").[41] Through MCI, BJS collected information about deaths in custody from the approximately 2,800 adult jails and 50 state departments of corrections, "track[ing] national trends in the number and causes of deaths occurring in correctional institutions."[42]

DCRA 2000 did not expressly require publication of state and local death data.[43] However, for the 20-year period from 2000 through 2019, BJS published information, statistics, and analyses of "comparative death rates across demographic categories, offense types and

[38] Death in Custody Reporting Act of 2000, Pub. L. No. 106-297.
[39] Death in Custody Reporting Act of 2000, Pub. L. No. 106-297; Department of Justice, Bureau of Justice Assistance, Violent Offender Incarceration and Truth-In-Sentencing (VOI/TIS) Incentive Program (https://bja.ojp.gov/program/violent-offender-incarceration-and-truth-sentencing-voitis-incentive-program/overview).
[40] Department of Justice, Office of the Inspector General, *Review of the Department of Justice's Implementation of the Death in Custody Reporting Act of* 2013, at 2-3 (Dec. 2018) (oig.justice.gov/reports/2018/e1901.pdf).
[41] Department of Justice, Office of the Inspector General, *Review of the Department of Justice's Implementation of the Death in Custody Reporting Act of* 2013, at 2 (Dec. 2018) (oig.justice.gov/reports/2018/e1901.pdf); Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in Correctional Institutions (MCI) (Formerly Deaths in Custody Reporting Program (DCRP)* (bjs.ojp.gov/data-collection/mortality-correctional-institutions-mci-formerly-deaths-custody-reporting-program) (BJS's national study of death in custody).
[42] Department of Justice, Office of the Inspector General, *Review of the Department of Justice's Implementation of the Death in Custody Reporting Act of* 2013, at 2 (Dec. 2018) (oig.justice.gov/reports/2018/e1901.pdf).
[43] Death in Custody Reporting Act of 2000, Pub. L. No. 106-297.

facility/agency characteristics."[44] BJS reported that it collected data from an average of 98% of all local jails and 100% of all state prisons.[45]

When DCRA 2000 expired in 2006, BJS continued to collect and publish the data specified in the law because BJS determined "they represent a unique national resource for understanding mortality in the criminal justice system."[46] BJS was able to continue collecting data under BJS's authorizing statute.[47]

In 2014, Congress reauthorized DCRA 2000.[48] The reauthorization restored and expanded DCRA 2000's mandates with four key additions concerning deaths in state and local custody.[49] *First*, it requires states to report "the law enforcement agency that detained, arrested, or was in the process of arresting the deceased," in addition to the fields required by DCRA 2000.[50] BJS had never before published information identifying the law enforcement agency holding the person who died.[51] *Second*, it requires DOJ to collect state reported death data in perpetuity, with no expiration.[52]

Third, it requires that by December 2016, two years after DCRA 2013 became law, DOJ issue a report to Congress that would "determine means by which [death in custody] information can be used to reduce the number of such deaths," and "examine the relationship, if any, between the number of such deaths and the actions of management of such jails, prisons, and other specified facilities relating to such deaths."[53] DOJ has not yet provided any DCRA 2013-required reporting to Congress. It does not expect to complete its DCRA 2013-required reporting before 2024, eight years past its required due date.[54] *Fourth*, it authorized the Attorney

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[44] Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Deaths in Custody Statistical Tables* (July 2010) (bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/dictabs.pdf); *see also* Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in Correctional Institutions (MCI) (Formerly Deaths in Custody Reporting Program (DCRP)* (bjs.ojp.gov/data-collection/mortality-correctional-institutions-mci-formerly-deaths-custody-reporting-program).

[45] Dr. E. Ann Carson, Bureau of Justice Statistics, *Report Comparing Bureau of Justice Statistics and Bureau of Justice Assistance Mortality Death Collections, to fulfill Terms of Clearance for OMB Control Number 1121-0249*, at 3 (May 11, 2021) (omb.report/icr/202105-1121-001/doc/111526800).

[46] Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Deaths in Custody Statistical Tables*, at 1 (July 2010) (bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/dictabs.pdf).

[47] 34 U.S.C. § 10132 (BJS is authorized to "collect and analyze statistical information, concerning the operations of the criminal justice system" at all levels of government, and to "publish, and disseminate uniform national statistics concerning all aspects of criminal justice.").

[48] Death in Custody Reporting Act of 2013, Pub. L. No. 113-242.

[49] Death in Custody Reporting Act of 2013, Pub. L. No. 113-242.

[50] Death in Custody Reporting Act of 2013, Pub. L. No. 113-242.

[51] Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in Correctional Institutions (MCI) (Formerly Deaths in Custody Reporting Program (DCRP)* (bjs.ojp.gov/data-collection/mortality-correctional-institutions-mci-formerly-deaths-custody-reporting-program).

[52] Death in Custody Reporting Act of 2013, Pub. L. No. 113-242.

[53] Death in Custody Reporting Act of 2013, Pub. L. No. 113-242.

[54] Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 7 (GAO-22-106033) (Sept. 20, 2022). DOJ has commissioned two studies in response to DCRA's reporting requirements. *See* Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022). DOJ informed the Subcommittee that it expects to produce the first report to Congress in late 2022 and the second report at some point after September 2024. *Id.*

General, at the Attorney General's discretion, to withhold up to 10% of a state's JAG grant funding from states or territories if that state failed to report DCRA data to DOJ.[55] To date, DOJ has not withheld any funds from states that accept JAG grants but did not report DCRA-required data to DOJ, and has not assessed state compliance with DCRA reporting.[56]

After Congress passed the reauthorization, BJS continued its collection and publication of death data.[57] On December 16, 2016, DOJ issued a report to Congress setting forth its plans for implementing DCRA.[58] Part of this plan included reassigning the DCRA 2013 state and local custodial death collection from BJS to BJA, a grant-making agency within OJP. DOJ explained its rationale for the change as follows:

> BJA administers the Byrne JAG Program and the compliance and penalty determinations that program requires. BJS will not administer the DCRA collection because its compliance is tied to the administration of the Byrne JAG Program, and BJS's statistical directives make clear that it "must function in an environment that is clearly separate and autonomous from the other administrative, regulatory, law enforcement, or policy-making activities" of the Department.[59]

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[55] Death in Custody Reporting Act of 2013, Pub. L. No. 113-242.

[56] Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022); Government Accountability Office, Briefing with Senate Permanent Subcommittee on Investigations (Sept. 8, 2022).

[57] Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in Correctional Institutions (MCI) (Formerly Deaths in Custody Reporting Program (DCRP)* (bjs.ojp.gov/data-collection/mortality-correctional-institutions-mci-formerly-deaths-custody-reporting-program).

[58] Department of Justice, *Report of the Attorney General to Congress Pursuant to the Death in Custody Reporting Act* (Dec. 16, 2016) (www.justice.gov/archives/page/file/918846/download).

[59] Department of Justice, *Report of the Attorney General to Congress Pursuant to the Death in Custody Reporting Act*, at 8 n.17 (Dec. 16, 2016) (www.justice.gov/archives/page/file/918846/download). In later years, DOJ characterized its rationale for reassigning the collection from BJS to BJA differently. In a BJS report dated May 11, 2021 and on BJS's website, BJS describes DOJ's rationale as follows:

> In 2016, the Department of Justice (DOJ) **decided to place more emphasis** on the section of P.L. 113-242 that concerned non-compliance with the data collection. Per the law, states that did not report on a quarterly basis individual-level data on deaths occurring in local jails, in state prisons, or in the process of arrest, could be penalized up to 10% of the DOJ-administered Justice Assistance Grants (JAG) awards. The DOJ determined that the Bureau of Justice Assistance (BJA) should manage collection of the data pursuant to the law because BJS, as a federal statistical agency, may not collect data for law enforcement purposes. BJA is not under similar requirements to collect data for statistical purposes only.

Dr. E. Ann Carson, Bureau of Justice Statistics, *Report Comparing Bureau of Justice Statistics and Bureau of Justice Assistance Mortality Death Collections, to fulfill Terms of Clearance for OMB Control Number 1121-0249*, at 3-4 (May 11, 2021) (omb.report/icr/202105-1121-001/doc/111526800) (emphasis added); Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in Correctional Institutions (MCI) (Formerly Deaths in Custody Reporting Program (DCRP)* (bjs.ojp.gov/data-collection/mortality-correctional-institutions-mci-formerly-deaths-custody-reporting-program) (emphasis added).

DOJ reasoned that the JAG funding penalty provision requires BJS to collect data for "enforcement purposes," which BJS is not permitted to do as a federal statistical agency.[60] Up until that point, BJS had been collecting death data in response to DCRA 2000 for approximately fifteen years.[61] BJS continued to collect this same data until January 1, 2020.[62]

In 2018, the DOJ Office of the Inspector General ("OIG") conducted a review of DOJ's plans to implement DCRA 2013.[63] DOJ OIG wrote, "We found that the Department's state DCRA data collection plan that BJA proposed in June 2018 may not produce the quality of data about deaths in custody necessary to achieve the intent of the law."[64] DOJ OIG's provided two reasons for this finding.[65] First, it would be duplicative of other collections and risk "confus[ing] and fatig[uing] data respondents, who in turn may submit low-quality data."[66] Second, the data collection methodology that BJA planned to employ—only seeking data from states themselves and "not fully leverag[ing] open sources"—might preclude BJA from achieving DCRA's primary purpose.[67] DOJ OIG's 2018 review also found that, despite the report being two years past due, DOJ did not have plans to issue the DCRA-required report due to Congress.[68]

BJS continued to collect, study, and publish information about deaths in state and local custody through the 2019 calendar year, and formally closed the MCI program on March 31, 2021.[69] BJA began collecting state and local death data in FY 2020, using a data collection

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[60] Dr. E. Ann Carson, Bureau of Justice Statistics, *Report Comparing Bureau of Justice Statistics and Bureau of Justice Assistance Mortality Death Collections, to fulfill Terms of Clearance for OMB Control Number 1121-0249*, at 4 (May 11, 2021) (omb.report/icr/202105-1121-001/doc/111526800).
[61] Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in Correctional Institutions (MCI) (Formerly Deaths in Custody Reporting Program (DCRP)* (bjs.ojp.gov/data-collection/mortality-correctional-institutions-mci-formerly-deaths-custody-reporting-program); Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022).
[62] Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in Correctional Institutions (MCI) (Formerly Deaths in Custody Reporting Program (DCRP)* (bjs.ojp.gov/data-collection/mortality-correctional-institutions-mci-formerly-deaths-custody-reporting-program); Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022).
[63] Department of Justice, Office of the Inspector General, *Review of the Department of Justice's Implementation of the Death in Custody Reporting Act of 2013* (Dec. 2018) (oig.justice.gov/reports/2018/e1901.pdf).
[64] Department of Justice, Office of the Inspector General, *Review of the Department of Justice's Implementation of the Death in Custody Reporting Act of 2013*, at 13-14 (Dec. 2018) (oig.justice.gov/reports/2018/e1901.pdf).
[65] Department of Justice, Office of the Inspector General, *Review of the Department of Justice's Implementation of the Death in Custody Reporting Act of 2013*, at 13-14 (Dec. 2018) (oig.justice.gov/reports/2018/e1901.pdf).
[66] Department of Justice, Office of the Inspector General, *Review of the Department of Justice's Implementation of the Death in Custody Reporting Act of 2013*, at 13-14 (Dec. 2018) (oig.justice.gov/reports/2018/e1901.pdf).
[67] Department of Justice, Office of the Inspector General, *Review of the Department of Justice's Implementation of the Death in Custody Reporting Act of 2013*, at 13-14 (Dec. 2018) (oig.justice.gov/reports/2018/e1901.pdf).
[68] Department of Justice, Office of the Inspector General, *Review of the Department of Justice's Implementation of the Death in Custody Reporting Act of 2013*, at i (Dec. 2018) (oig.justice.gov/reports/2018/e1901.pdf).
[69] Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in Correctional Institutions (MCI) (Formerly Deaths in Custody Reporting Program (DCRP)* (bjs.ojp.gov/data-collection/mortality-correctional-institutions-mci-formerly-deaths-custody-reporting-program). BJS continues to collect data on deaths in federal custody. *See, e.g.*, Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, Federal Deaths in Custody and During Arrest, 2020—Statistical Tables (July 2022) (https://bjs.ojp.gov/content/pub/pdf/fdcda20st.pdf).

methodology and survey instrument that were both different from what BJS employed.[70] In May 2022, President Biden issued an Executive Order calling for DOJ to publish a report on the steps the Department has taken to implement DCRA 2013.[71] The Department published this report on September 16, 2022.[72]

b. DOJ's Flawed FY 2020 Collection

Because BJS collected death data according to the calendar year and BJA collected death data according to the fiscal year, BJS's collection overlapped with BJA's for three months—from October through December 2019.[73] As a condition for approving the continued collection of MCI data for calendar years 2018 and 2019, the Office of Management and Budget ("OMB") required BJS to issue a report comparing its collection to BJA's for the overlapping period.[74] BJS issued this report to OMB on May 11, 2021.[75] BJS identified numerous shortcomings in BJA's methodology and significant gaps in its collection.

Among the shortcomings BJS found were:

- "When compared to [BJS], BJA's data collection did not capture any state prison deaths in 11 states or any local jail deaths in 12 states and the District of Columbia."[76]

- "BJA's collection included only 38.9% of local jail deaths and 66.3% of state prison deaths" that BJS collected.[77]

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[70] Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022); *see also* Dr. E. Ann Carson, Bureau of Justice Statistics, *Report Comparing Bureau of Justice Statistics and Bureau of Justice Assistance Mortality Death Collections, to fulfill Terms of Clearance for OMB Control Number 1121-0249*, at 5-8 (May 11, 2021) (omb.report/icr/202105-1121-001/doc/111526800) (discussing BJA's data collection methodology and survey tool—Performance Measurement Tool).

[71] Exec. Order No. 14074, 87 Fed. Reg. 32945 (May 25, 2022).

[72] Department of Justice, Office of the Attorney General, *Department of Justice Implementation of the Death in Custody Reporting Act of 2013* (Sept. 16, 2022) (https://bja.ojp.gov/doc/DOJ-Implementation-of-DCRA.pdf).

[73] Dr. E. Ann Carson, Bureau of Justice Statistics, *Report Comparing Bureau of Justice Statistics and Bureau of Justice Assistance Mortality Death Collections, to fulfill Terms of Clearance for OMB Control Number 1121-0249*, at 1 (May 11, 2021) (omb.report/icr/202105-1121-001/doc/111526800).

[74] Dr. E. Ann Carson, Bureau of Justice Statistics, *Report Comparing Bureau of Justice Statistics and Bureau of Justice Assistance Mortality Death Collections, to fulfill Terms of Clearance for OMB Control Number 1121-0249*, at 1 (May 11, 2021) (omb.report/icr/202105-1121-001/doc/111526800).

[75] Dr. E. Ann Carson, Bureau of Justice Statistics, *Report Comparing Bureau of Justice Statistics and Bureau of Justice Assistance Mortality Death Collections, to fulfill Terms of Clearance for OMB Control Number 1121-0249* (May 11, 2021) (omb.report/icr/202105-1121-001/doc/111526800).

[76] Dr. E. Ann Carson, Bureau of Justice Statistics, *Report Comparing Bureau of Justice Statistics and Bureau of Justice Assistance Mortality Death Collections, to fulfill Terms of Clearance for OMB Control Number 1121-0249*, at 2 (May 11, 2021) (omb.report/icr/202105-1121-001/doc/111526800).

[77] Dr. E. Ann Carson, Bureau of Justice Statistics, *Report Comparing Bureau of Justice Statistics and Bureau of Justice Assistance Mortality Death Collections, to fulfill Terms of Clearance for OMB Control Number 1121-0249*, at 2 (May 11, 2021) (omb.report/icr/202105-1121-001/doc/111526800).

- States reported 1,246 deaths to BJS but only 744 deaths to BJA (59.7% of the deaths reported to BJS).[78]

- Six states did not report any deaths in custody to BJA, but did report deaths to BJS.[79]

- There were various data quality concerns with BJA's collection, such as inaccuracies and missing fields. For example, 56 of the deaths reported to BJA as deaths during arrest had actually occurred in jails and prisons when reported to BJS.[80]

c. DOJ's Flawed FY 2021 Collection

On March 23, 2022, PSI requested that GAO study the submissions that BJA had received from states for FY 2021, and report to the Subcommittee on whether DOJ had taken steps to rectify the problems previously identified by BJS with BJA's FY 2020 data collection.[81] GAO's findings, like BJS's the year prior, revealed myriad deficiencies in BJA's collection.

GAO found the following for FY 2021 data:

- At least 341 missing and potentially reportable prison deaths were disclosed on states' public websites but were not collected by BJA.[82] At least 649 missing arrest deaths were reported in a public database maintained by a non-profit civil rights organization, but were not collected by BJA.[83] Together, GAO determined that BJA missed at least 990 prison and arrest-related deaths.[84] GAO informed

[78] Dr. E. Ann Carson, Bureau of Justice Statistics, *Report Comparing Bureau of Justice Statistics and Bureau of Justice Assistance Mortality Death Collections, to fulfill Terms of Clearance for OMB Control Number 1121-0249*, at 2 (May 11, 2021) (omb.report/icr/202105-1121-001/doc/111526800).
[79] Dr. E. Ann Carson, Bureau of Justice Statistics, *Report Comparing Bureau of Justice Statistics and Bureau of Justice Assistance Mortality Death Collections, to fulfill Terms of Clearance for OMB Control Number 1121-0249*, at 2 (May 11, 2021) (omb.report/icr/202105-1121-001/doc/111526800).
[80] Dr. E. Ann Carson, Bureau of Justice Statistics, *Report Comparing Bureau of Justice Statistics and Bureau of Justice Assistance Mortality Death Collections, to fulfill Terms of Clearance for OMB Control Number 1121-0249*, at 2, 8 (May 11, 2021) (omb.report/icr/202105-1121-001/doc/111526800).
[81] Letter from Chair Jon Ossoff, Senate Permanent Subcommittee on Investigations, to Government Accountability Office (Mar. 23, 2022).
[82] Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 10 n.33 (GAO-22-106033) (Sept. 20, 2022). In its report, GAO noted that it was "relying on states' disclosures of deaths in custody and did not independently verify that these deaths occurred in custody and therefore refer to these deaths as potentially reportable." *Id.*
[83] In its report, GAO noted, "Mapping Police Violence uses media accounts and other open-source information to collect information on deaths. Therefore, if an arrest-related death was not made public, it would not be included in this database and we could not determine if it was captured in DCRA data or not." Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 10 n.33 (GAO-22-106033) (Sept. 20, 2022); Campaign Zero, *Mapping Police Violence* (updated Mar. 31, 2022) (mappingpoliceviolence.org/).
[84] Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 10 n.33 (GAO-22-106033) (Sept. 20, 2022).

the Subcommittee that it could not assess whether BJA missed jail deaths because there is no centralized, public repository of that information.[85] GAO estimated that the 990 missing deaths was an undercount of unreported deaths.[86]

- Fifty-six states and territories received JAG funding and were required by law to report custodial death information to BJA.[87] Only 47 states reported deaths in custody.[88] For the nine states that did not report to BJA, GAO found that at least four of the states had deaths in custody—124 deaths in total.[89]

- Seventy percent of death in custody records produced by states to BJA in FY 2021 were missing at least one category of information that DCRA required DOJ to collect; approximately 40% of the records did not include a description of the circumstances surrounding the death; and 32% of the records were missing more than one DCRA-required field.[90]

- Only two states submitted DCRA data to BJA that contained all of the required data fields.[91] Seven states did not produce a single record to DOJ with all the required data fields.[92]

II. DOJ's Failure to Implement DCRA 2013

Deaths in government custody can be probative of policy or administrative failures.[93] Understanding where and why prisoners are dying can reveal breakdowns in medical care,

[85] Government Accountability Office, Briefing with Senate Permanent Subcommittee on Investigations (Sept. 8, 2022).
[86] Government Accountability Office, Briefing with Senate Permanent Subcommittee on Investigations (Sept. 8, 2022).
[87] Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 10 n.34 (GAO-22-106033) (Sept. 20, 2022). GAO did not disclose to the Subcommittee the names of the states that had not submitted data to BJA.
[88] Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 10 n.34 (GAO-22-106033) (Sept. 20, 2022).
[89] Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 10 n.34 (GAO-22-106033) (Sept. 20, 2022).
[90] Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 9 (GAO-22-106033) (Sept. 20, 2022).
[91] Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 10 (GAO-22-106033) (Sept. 20, 2022).
[92] Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 10 (GAO-22-106033) (Sept. 20, 2022).
[93] University of California Los Angeles School of Law Carceral Mortality Project, Briefing with Senate Permanent Subcommittee on Investigations (Aug. 3, 2022); Professor Andrea Armstrong, Loyola University New Orleans School of Law, Briefing with Senate Permanent Subcommittee on Investigations (Apr. 19, 2022).

substance abuse treatment, anti-drug diversion programs, mental health services, or safe custodial environments.[94]

a. DOJ's Statutorily-Prescribed Reporting Will Be at Least Eight Years Late

DCRA 2013 required that DOJ report to Congress by December 18, 2016 on how the custodial death information that it had collected can be used to "to reduce the number of such deaths" and "examine the relationship, if any, between the number of such deaths and the actions of management of such jails, prisons, and other specified facilities relating to such deaths."[95]

DOJ has failed to comply with this requirement in two ways. First, DOJ does not intend complete these reporting requirements before September 2024, eight years past the statutory deadline.[96] Second, the data that BJA did collect for FY 2020 and FY 2021 missed hundreds of deaths and reports from multiple states.[97] Going forward, BJA intends to use the same failed data collection methodologies used in its FY 2020 and FY 2021 collections, including the same data collection tool and relying on state collection agencies.[98]

b. DOJ Has Disrupted a 20-Year Data Set

From 2000 through 2019, DOJ demonstrated its ability to collect comprehensive data about deaths in state and local custody, assembling detailed information about why incarcerated people died by state, type of detention facility, and cause.[99] For example, BJS's data collection, study, and publication revealed important information including:

- From 2001 through 2019, approximately 84,537 prisoners in America died in state or local facilities.[100]

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[94] University of California Los Angeles School of Law Carceral Mortality Project, Briefing with Senate Permanent Subcommittee on Investigations (Aug. 3, 2022); Professor Andrea Armstrong, Loyola University New Orleans School of Law, Briefing with Senate Permanent Subcommittee on Investigations (Apr. 19, 2022).

[95] Death in Custody Reporting Act of 2013, Pub. L. No. 113-242.

[96] Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022).

[97] Government Accountability Office, *Deaths in Custody: Additional Action Needed to Help Ensure Data Collected by DOJ are Utilized*, at 10 n.33 (GAO-22-106033) (Sept. 20, 2022). DOJ's position is that it has not yet determined whether this data can be used to support the DCRA-required reporting. *See* Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022).

[98] In an interview with the Subcommittee, Dr. Wyrick described a number of strategies that DOJ plans to employ in an attempt to improve reporting quality and completeness, including additional training and technical assistance to state reporters. Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022). However, these strategies will not change the underlying data collection methodology that BJA used in FY 2020, FY 2021, and in subsequent years.

[99] *See* Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in State and Federal Prisons 2001-2019—Statistical Tables* (Dec. 2021) (bjs.ojp.gov/content/pub/pdf/msfp0119st.pdf); Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in Local Jails 2000-2019—Statistical Tables* (Dec. 2021) (bjs.ojp.gov/content/pub/pdf/mlj0019st.pdf); Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022).

[100] This figure is derived from combining data from BJS reports on (1) deaths in state custody, and (2) deaths in local jails. *See* Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in State*

- Suicide was the single leading cause of death in local jails in 2019.[101]

- "Jails with an average daily population of 49 or fewer inmates had the highest mortality rates each year from 2000 to 2019."[102]

- From 2001 through 2019, "[t]he highest average annual rate of homicide in state prisons [] was in South Carolina (15 per 100,000 [prisoners]) and Oklahoma (14 per 1000,000 [prisoners])."[103] New Hampshire, North Dakota, Vermont, and Wyoming reported no prison homicides during this period.[104]

DOJ has disrupted this 20-year data set in two ways. First, BJA failed to collect complete or accurate data for FY 2020 and FY 2021.[105] Second, BJA changed its data collection methodology and survey instrument, ending certain important data sets and preventing analysis of certain longitudinal trends.[106] DOJ is not required to—and has no specific plans to—publish any state and local custodial death information for FY 2020, FY 2021, or beyond.[107]

c. DOJ Has Never Reported on Facility-Level Death Data

DCRA 2013 required states accepting JAG funding to report—and DOJ to collect—data identifying the law enforcement agency holding the person who died in custody, and then use that information to "examine the relationship, if any, between the number of such deaths and the actions of management of such jails, prisons, and other specified facilities relating to such deaths."[108] Unlike the other data elements that DCRA 2013 requires DOJ to collect—which BJS

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and Federal Prisons 2001-2019—Statistical Tables (Dec. 2021) (bjs.ojp.gov/content/pub/pdf/msfp0119st.pdf); Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in Local Jails 2000-2019—Statistical Tables* (Dec. 2021) (bjs.ojp.gov/content/pub/pdf/mlj0019st.pdf).

[101] Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in Local Jails 2000-2019—Statistical Tables*, at 2 (Dec. 2021) (bjs.ojp.gov/content/pub/pdf/mlj0019st.pdf).

[102] Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in Local Jails 2000-2019—Statistical Tables*, at 1 (Dec. 2021) (bjs.ojp.gov/content/pub/pdf/mlj0019st.pdf).

[103] Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in State and Federal Prisons 2001-2019—Statistical Tables*, at 5 (Dec. 2021) (bjs.ojp.gov/content/pub/pdf/msfp0119st.pdf).

[104] Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Mortality in State and Federal Prisons 2001-2019—Statistical Tables*, at 5 (Dec. 2021) (bjs.ojp.gov/content/pub/pdf/msfp0119st.pdf).

[105] *See* Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022).

[106] Professor Andrea Armstrong, Loyola University New Orleans School of Law, Briefing with Senate Permanent Subcommittee on Investigations (Apr. 19, 2022).

[107] In an interview with the Subcommittee, Dr. Wyrick stated that he was unaware of whether the Department has made a decision publishing state and local death data collected after FY 2021. Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022). He also said that the Department is not planning to publish any death in custody information collected by BJA for FY 2020 and FY 2021 because the data that BJA had collected was incomplete and could be misleading if disclosed. *Id.*

[108] Death in Custody Reporting Act of 2013, Pub. L. No. 113-242.

collected, studied, and published from 2000 through 2019—DOJ has never before publicly reported facility-level death data.[109]

Faced with limited publicly available information identifying the specific facilities where prisoners are dying, journalists and non-profit organizations have undertaken piecemeal efforts to compile this information by submitting open records requests to individual jails and prison systems and then publishing the results.[110] They have stepped in to attempt the data collection that DOJ is statutorily obligated and best situated to do, as DOJ has the resources, expertise, and tools to facilitate compliance and conduct cross-jurisdictional data analysis.[111]

In October 2020, one media organization, *Reuters*, disclosed the results of its nationwide investigation into jail deaths.[112] Per *Reuters*, it engaged in this investigation because "[t]he U.S. government collects detailed data on who's dying in which jails around the country – but won't let anyone see it."[113] *Reuters* submitted 1,500 open records requests for death data from every large jail in the United States and the ten largest individual jails in every state for 2008 to 2019.[114] The *Reuters* review of deaths in custody offered critical examples of why disclosure of facility-level death can help identify troubling trends in prisons and jails.

For example, on October 31, 2016, police officers in Baton Rouge, Louisiana, arrested Jonathan Fano for several misdemeanors after he suffered a mental health episode associated with his diagnoses of bipolar disorder and depression while traveling from Florida to California by bus.[115] While held at the East Baton Rouge Parish Prison ("EBRPP") pending adjudication of

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[109] Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022). The Subcommittee's investigation into corruption, abuse, and misconduct at the U.S. Penitentiary Atlanta ("USPA") showed how facility-level death data can help shed light on whether prison and jail conditions are safe, humane, and managed effectively. USPA—a Federal Bureau of Prisons ("BOP") facility rife with dangerous contraband, security failings, and inhumane conditions of incarceration since at least 2013—had 13 prisoner suicides from 2012 to 2021 and five suicides within the two-year period between 2019 and 2021. There were more prisoner suicides at USPA between 2016 and 2021 than any other BOP facility. Senate Permanent Subcommittee on Investigations, *Hearing on Corruption, Abuse, and Misconduct at U.S. Penitentiary Atlanta,* 117th Cong. (July 26, 2022) (hsgac.senate.gov/subcommittees/investigations/hearings/corruption-abuse-and-misconduct-at-us-penitentiary-atlanta); Memorandum from Sonya Thompson, Assistant Director of the Reentry Services Division to J.A. Keller, Southeast Regional Director re Psychology Reconstruction response (PSIDocumentProduction8-07082022-002846); Psychology Reconstruction of an Inmate Suicide at USPA (PSIDocumentProduction8-07082022-002).

[110] *See, e.g.*, Incarceration Transparency (www.incarcerationtransparency.org/) (accessed Sept. 13, 2022).

[111] Death in Custody Reporting Act of 2013, Pub. L. No. 113-242; University of California Los Angeles School of Law Carceral Mortality Project, Briefing with Senate Permanent Subcommittee on Investigations (Aug. 3, 2022); Dr. Phelan Wyrick, Department of Justice, Interview with Senate Permanent Subcommittee on Investigations (Sept. 12, 2022).

[112] Grant Smith, *Jail Deaths in America: Data and Key Findings of Dying Inside*, Reuters (Oct. 16, 2020) (www.reuters.com/investigates/special-report/usa-jails-graphic/).

[113] Peter Eisler, et al., *Why 4,998 Died in U.S. Jails Without Getting Their Day in Court*, Reuters (Oct. 16, 2020) (www.reuters.com/investigates/special-report/usa-jails-deaths/).

[114] Grant Smith, *Jail Deaths in America: Data and Key Findings of Dying Inside*, Reuters (Oct. 16, 2020) (www.reuters.com/investigates/special-report/usa-jails-graphic/).

[115] Fano was charged with obscenity, criminal trespass, disturbing the peace, resisting arrest, battery on an Officer, and simple criminal damage to property. *Zavala v. City of Baton Rouge*, No. 17-656-JWD-EWD (M.D. La. Sept. 20, 2018). The Fano family complaint in civil litigation following Fano's death alleged that no officer was injured

the charges against him, Fano was denied psychotropic medications.[116] He hung himself on February 2, 2017 and was declared dead three days later.[117] *Reuters* reported that from 2009 to 2019, there were 45 deaths at the EBRPP—an average of 4.5 deaths per year—more than double the national average of jail deaths.[118] Given the higher than average death rate at this facility, it is possible that DCRA data could have identified the trend and allowed DOJ and EBRPP to take corrective measures.

Jonathan Fano's sister, Vanessa Fano, told the Subcommittee that for the three months her brother was incarcerated at EBRPP, he was just "trying not to die in there."[119] Vanessa Fano provided the Subcommittee with a letter that she received from him on or about January 2017, while held at EBRPP.

during the arrest. Complaint at 6, *Zavala v. City of Baton Rouge*, No. 17-656-JWD-EWD (M.D. La. Sept. 20, 2018); *see also* Vanessa Fano, Interview with Senate Permanent Subcommittee on Investigations (Apr. 20, 2022).

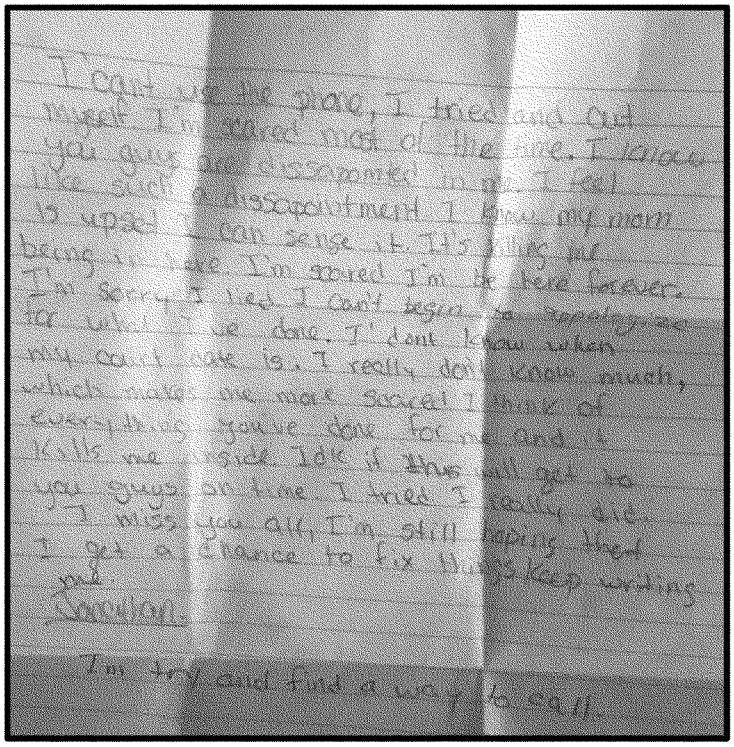
[116] *Zavala v. City of Baton Rouge*, No. 17-656-JWD-EWD (M.D. La. Sept. 20, 2018); Vanessa Fano, Interview with Senate Permanent Subcommittee on Investigations (Apr. 20, 2022).

[117] *Zavala v. City of Baton Rouge*, No. 17-656-JWD-EWD (M.D. La. Sept. 20, 2018); Vanessa Fano, Interview with Senate Permanent Subcommittee on Investigations (Apr. 20, 2022).

[118] *See* Grant Smith, *Jail Deaths in America: Data and Key Findings of Dying Inside*, Louisiana PDF, Reuters (Oct. 16, 2020) (www.reuters.com/investigates/special-report/usa-jails-graphic/).

[119] Vanessa Fano, Interview with Senate Permanent Subcommittee on Investigations (Apr. 20, 2022).

Figure 2: Letter by Jonathan Fano[120]



For another example, in February 2014, officers arrested Matthew Loflin for possession, a non-violent drug charge, and incarcerated him at the Chatham County Detention Center ("CCDC") in Georgia.[121] From February to April 2014, Loflin repeatedly requested medical treatment for symptoms suggestive of congestive heart failure, including swelling of his extremities, difficulty breathing, and coughing up blood, but his requests were denied for weeks.[122] Loflin died on April 24, 2014 after suffering irreversible brain damage following

[120] Email from Vanessa Fano to Senate Permanent Subcommittee on Investigations Staff (June 22, 2022).
[121] *Maley v. Corizon Health, Inc.*, No. CV416-060, 2018 WL 1002635 (S.D. Ga. Feb. 21, 2018); Jason Szep, et al., *Special Report: U.S. Jails are Outsourcing Medical Care – and the Death Toll is Rising*, Reuters (Oct. 26, 2020) (www.reuters.com/investigates/special-report/usa-jails-privatization/).
[122] *See* Belinda Maley, Interview with Senate Permanent Subcommittee on Investigations (May 4, 2022); Jason Szep, et al., *Special Report: U.S. Jails are Outsourcing Medical Care – and the Death Toll is Rising*, Reuters (Oct. 26, 2020) (www.reuters.com/investigates/special-report/usa-jails-privatization/).

hospitalization for heart failure.[123] *Reuters* identified 22 people who died at CCDC from 2009 through 2019.[124] Of these deaths, 50% were due to illness.[125] There is the potential that had DCRA been implemented properly, the trend in illness-related deaths could have been identified and corrective measures taken. The last time Loflin spoke with his mother, days before his death, he told her that he was afraid he was going to die. A transcript of this recorded phone call follows:

[123] Jason Szep, et al., *Special Report: U.S. Jails are Outsourcing Medical Care – and the Death Toll is Rising*, Reuters (Oct. 26, 2020) (www.reuters.com/investigates/special-report/usa-jails-privatization/).
[124] *See* Grant Smith, *Jail Deaths in America: Data and Key Findings of Dying Inside*, Georgia PDF, Reuters (Oct. 16, 2020) (www.reuters.com/investigates/special-report/usa-jails-graphic/).
[125] Grant Smith, *Jail Deaths in America: Data and Key Findings of Dying Inside,* Georgia PDF, Reuters (Oct. 16, 2020) (www.reuters.com/investigates/special-report/usa-jails-graphic/).

Figure 3: Transcript of Recorded Call on March 28, 2014 from the Chatham County Detention Center[126]

Mother: Matthew?

Loflin: Hey.

Mother: Okay, listen I found out everything I can. I'm gonna try to get... um, I'm having lawyers and the sheriff and all this other kind of shit trying to make it so I can come in there and see you. I am trying also to get you out of there and get you . . .

Loflin: I need to go to the hospital.

Mother: I know...

Loflin: I'm gonna die in here.

Mother: I know you are Matthew. I am doing everything I can to get you out, and so I can see you. Hello?

Loflin: Yeah.

Mother: They're doing everything they can.

PHONE: There are 15 seconds remaining.

Loflin: I've been coughing up blood and my feet are swollen. It hurts, Mom.

Mother: I know Matthew, I know what is wrong with you. I told you this would happen. I love you, Matthew. They are going to cut us off...

Loflin: I love you too. I'm gonna die in here.

III. Conclusion

DOJ has failed to effectively implement DCRA 2013, undermining the effective, comprehensive, and accurate collection of custodial death data. These failures were preventable. DOJ's September 16, 2022 report, released pursuant to President Biden's executive order, is an

[126] PSI staff transcribed an audio clip that was first released by *Reuters*. Jason Szep, et al., *Special Report: U.S. Jails are Outsourcing Medical Care – and the Death Toll is Rising*, Reuters (Oct. 26, 2020) (www.reuters.com/investigates/special-report/usa-jails-privatization/); *see also Loflin_audio.wav* (hdrive.google.com/file/d/14H7slAViw_KZmDdDkQYivsB9Yj5rUwWR/view).

important step to improve DOJ's efforts to better implement DCRA 2013.[127] DOJ must act quickly to remedy the outstanding implementation failures, and Congress should continue to monitor DOJ's implementation efforts.

[127] Department of Justice, Office of the Attorney General, *Department of Justice Implementation of the Death in Custody Reporting Act of 2013* (Sept. 16, 2022) (https://bja.ojp.gov/doc/DOJ-Implementation-of-DCRA.pdf).

Statement of Congressman Robert C. "Bobby" Scott
Senate Committee on Homeland Security and Government Affairs
Permanent Subcommittee on Investigations Hearing
"Uncounted Deaths in America's Prisons and Jails: How the Department of Justice Failed to Implement the Death in Custody Reporting Act"
Tuesday, September 20, 2022

Thank you, Chairman Ossoff and Ranking Member Johnson, for convening this hearing to discuss the issues surrounding the implementation of the Death in Custody Reporting Act (DCRA). This is an issue I have worked on for 22 years. I was the lead cosponsor with then-Congressman Asa Hutchinson of Arkansas of the original Death in Custody Reporting Act of 2000 and I was proud to lead the reauthorization of the law in 2014. Unfortunately, as I know this hearing will highlight, eight years later the Department of Justice (DOJ) through three administrations has been derelict in its duty to fully collect accurate information about deaths that occur in the custody of law enforcement.

The Death in Custody Reporting Act is an important law that simply requires the DOJ to collect data from states and federal law enforcement on the number of individuals who died while being detained, under arrest, in the process of being arrested, incarcerated, or otherwise in custody. The Department has abandoned the law's goal of collecting data about all deaths in the occur in custody and instead has engaged in bureaucratic shuffling by moving the data collection effort from one agency to another. I am unaware of any concerted effort over the last eight years by the Department to inform states on how to best comply with the law, and that states may be subject to losing up to 10 percent of their federal DOJ grant funds they receive for failing to comply. The Department seems content that some states are voluntarily reporting, while others may be completely unaware of their obligation to report or are intentionally ignoring the law.

An accurate, nationwide count on the number of individuals dying while in the custody of law enforcement is critical in assessing the scope of a problem that persists in this country. Without accurate government data, it is difficult to identify variables that lead to an unnecessary and unacceptable risk of individuals dying in custody or during an arrest. The information is needed so policymakers and elected officials at all levels of government will be in a position to identify trends, bad actors, and enact initiatives that can reduce incidences of avoidable deaths in our criminal justice system.

Only now, as this congressional hearing is convened, has the Department decided that they are unable to execute the law as passed by Congress eight years ago. Since 2014 and through multiple administrations, the DOJ has continued to ignore their legal obligation and people have continued dying in custody – and there remains no complete and accurate federal data collection effort to track this information. This is a simple task that has been needlessly complicated.

Thank you again for convening this hearing. I look forward to the Department fully implementing the law without further delay.

Written Statement of the American Civil Liberties Union Foundation

For a Hearing on

Uncounted Deaths in America's Prisons and Jails: How the Department of Justice Failed to Implement the Death in Custody Reporting Act

Submitted to the Permanent Subcommittee on Investigations
of the U.S. Senate Committee on Homeland Security and Governmental Affairs

Sept. 20, 2022

ACLU National Prison Project
David C. Fathi, Director
Tammie Gregg, Deputy Director
Corene Kendrick, Deputy Director

I. Background

On behalf of the American Civil Liberties Union ("ACLU") and its more than 1.5 million members, supporters, and activists, and 53 nationwide affiliates, we commend the Senate Homeland Security and Government Affairs Committee's Permanent Subcommittee on Investigations for its leadership in convening this bipartisan hearing to examine the continuing problem of deaths in America's prisons and jails going reported, and the problems with the collection of data by the U.S. Department of Justice ("DOJ") pursuant to the Deaths in Custody Reporting Act. This hearing, presenting the GAO's findings on Deaths in Custody, is an important first step in addressing the crisis of the nation's failure to have accurate data about the deaths of people in carceral settings, especially in light of the thousands of incarcerated people who have died due to COVID-19 in our country's prisons, jails, and immigration detention facilities over the past 2-1/2 years. We thank Chairman Ossoff and Ranking Member Johnson for holding this hearing, and offer our thanks and deepest condolences to the witnesses who bravely testified to the Subcommittee about their families' agonizing experiences after their loved ones died in custody, deaths that went unacknowledged and unreported to DOJ.

The ACLU is dedicated to the principles of liberty, justice, and equality embodied in our nation's Constitution and civil rights laws, and to protecting the civil liberties of all people in the United States. Consistent with that mission, the ACLU established the National Prison Project ("NPP") in 1972 to protect the rights of incarcerated people, to improve conditions within carceral settings, and to address the laws and policies that have led to the United States being the world leader in mass incarceration. For years, the ACLU has been at the forefront of the fight against mass incarceration and its devastating impact on the people and their families who become ensnared in the criminal legal system, the failure to increase a proportional increase in public safety, and its disproportionate effect on communities of color.

When originally passed in 2000, the Death in Custody Reporting Act ("DCRA") required the Attorney General to collect information on deaths in custody from states and municipalities, including persons under arrest, en route to be incarcerated or who is incarcerated. In its 2014 reauthorization (P.L. 113-242, 128 stat. 2860, 42 U.S.C. § 137627a), the head of each federal law enforcement agency also was required to report similar information annually to the Attorney General. As detailed further below in Part III, the 2018 DOJ Office of Inspector General's review of the Federal Deaths in Custody Reporting Program ("FDCRP") found that the majority of federal agencies—including the Federal Bureau of Prisons—were not reporting this data fully and accurately.[1]

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[1] *See* U.S. Dep't of Justice, Off. of Inspector General, Evaluations & Inspections Div., *Review of the Department of Justice's Implementation of the Death in Custody Reporting Act of 2013*, Review No. 19-01 (Dec. 2018), (hereinafter "2018 OIG Review"), available at https://oig.justice.gov/reports/2018/e1901.pdf.

There were many problematic findings in the GAO report, but key among them was that "even if these data were of sufficient quality, DOJ is not required by DCRA to publish state death in custody data and, as of September 2022, had no plans to do so."[2]

The bottom line is that for years, DOJ has failed to fully implement DCRA, and to the extent information has been gathered, DOJ has not endeavored to ensure that the data is complete or accurate, and has chosen to not make the data publicly available. This is unacceptable.

II. The GAO and Permanent Subcommittee's Report

It is critical that DOJ collect accurate and complete information about the deaths of people while in the custody of police and carceral agencies. Without this information, there is no transparency into what goes on in our nation's prisons, jails, juvenile detention, and immigration detention centers, or in law enforcement custody. The lack of transparency stymies the ability to identify the root causes of preventable deaths. For example, detailed information can help oversight entities and correctional leaders to determine if the deaths are due to inadequate mental health and medical care, the locations where deaths occur (for example, in solitary confinement units), inadequate numbers of health care or custody staff given the facility's incarcerated population, failures by custody staff to protect incarcerated people from violence, and/or lack of training or supervision of custodial or police officers.

Yet as the GAO's report to this Subcommittee and this hearing has revealed, the problems are more profound than originally believed. DOJ's shift in responsibility for data collection to the Bureau of Justice Assistance ("BJA") shows that its methodology is clearly inadequate, as it only relies upon states' reporting, fails to collect information from local or municipal agencies, and BJA does not supplement its data collection information with additional independent sources of death information.[3]

Furthermore, DOJ's failure to study the state-level data for purposes of the report to Congress required by the 2014 reauthorization, (34 U.S.C. § 60105(f)(1)(A)), and originally due to Congress in December 2016 is unacceptable. DOJ reports that a

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[2] U.S. Gov't Accountability Office, *DEATHS IN CUSTODY: Additional Action Needed to Help Ensure Data Collected by DOJ Are Utilized*, GAO-22-106033, at 7 (Sept. 20, 2022), available at https://www.gao.gov/assets/gao-22-106033.pdf. *See also id.* at 13-15.

[3] 2018 OIG Review at 16-18. See also *id.* at 3, 17 (noting that when BJS administered DCRA, it proposed to validate states' reporting with "a review of open sources, including news outlets, official agency documents, and other publicly available information," as well as "survey[s] [of] state and local law enforcement agencies" and "Medical Examiner's and Coroner's offices.")

consultant finally completed the first part of the report—analyzing the means by which death in custody data could be used to reduce the number of such deaths—and it will be provided to Congress by December 2022, six years beyond its due date.[4] Moreover, the 2014 reauthorization also required that the report (originally due in December 2016) examine the relationship between the numbers of deaths and the actions (or inactions) by carceral facility management and operations. 34 U.S.C. § 60105(f)(1)(B). DOJ officials reported that this portion of the report would not be provided until some point in 2024 or later.[5]

Most shocking are the failures of DOJ highlighted by Chairman Ossoff in his opening remarks:

- DOJ has failed to collect complete or accurate state and local deaths in custody data for the past two years, including a failure in FY 2021 to identify almost 1,000 deaths, undoubtedly an undercount of the deficiencies;
- Of the records collected by DOJ in FY 2021, 70 percent were incomplete, and 40 percent failed to capture the circumstances of death;
- In the first quarter of FY 2020, DOJ failed to collect *any* state prison data from eleven states, or *any* jail death data from 12 states and the District of Columbia.

These failures are all the more shocking, given that in the past two and a half years, our nation's prisons, jails, juvenile lock-ups, and immigration detention centers have been battered by the COVID-19 pandemic, with hundreds of thousands of incarcerated people infected by the virus, and thousands dying from the virus. Without knowing the full toll of the virus on these carceral settings, it is all the more difficult for public health and correctional officials to prepare for future coronavirus variants or other epidemics.

III. Areas for Additional Subcommittee Research and Hearings

We hope that today's hearing is the first of more hearings into the failures by DOJ to ensure that correctional and law enforcement agencies transparently and properly report all deaths of people in their custody. First, DOJ is not accurately tracking or requiring reports of deaths in custody of people held in federal custody — both in the Federal Bureau of Prisons ("BOP"), as well as in the Department of Homeland Security ("DHS"), including Immigration and Customs Enforcement ("ICE") and Customs and Border Patrol ("CBP") custody. Second, the failure of DOJ/BJA to integrate data from third-party publicly-available sources has completely hidden the true toll of deaths that have occurred at the hands of police and other law enforcement.

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[4] GAO, *DEATHS IN CUSTODY*, at 7.
[5] *Id.*

The ACLU asks the Subcommittee (a) to investigate these two additional problematic areas related to DOJ's failure to properly implement DCRA; (b) request further audits and analysis by the GAO, and corrective improvement recommendations, if appropriate; and (c) hold additional public hearings to learn about the outcomes of investigations and audits, and to shine a light on the real world impact of DOJ's failure to hold federal carceral systems and law enforcement accountable for the true numbers of deaths in custody.

A. Hidden Deaths of People in Federal Custody

The 2018 DOJ Office of Inspector General's review of the Federal Deaths in Custody Reporting Program ("FDCRP") found that the majority of federal agencies—including the Federal Bureau of Prisons—were not reporting this data fully and accurately.[6] Unfortunately, the responses by BOP and DHS's immigration agencies to the COVID-19 pandemic, have made these data failures all the more problematic.[7]

1. BOP Practices

In March 2021, the UCLA School of Law's COVID Behind Bars Data Project reported that the BOP had been quietly scrubbing from its public COVID-19 dashboard, data regarding infection rates.[8] UCLA researchers noticed that month that the number of cumulative positive test results was starting go down, which they described as "an illogical trend for a number that presumably can only increase over time, as more tests come back positive."[9] Incredibly, the UCLA researchers reported, the BOP confirmed to them that this odd downturn was "not in fact, an error. Rather, it was the outcome of an intentional reporting choice." BOP confirmed to the UCLA researchers that it was systematically removing from its cumulative count, any persons who had tested positive but subsequently was released from custody. The UCLA researchers went back through

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[6] *See* U.S. Dep't of Justice, Off. of Inspector General, Evaluations & Inspections Div., *Review of the Department of Justice's Implementation of the Death in Custody Reporting Act of 2013*, Review No. 19-01 (Dec. 2018), available at https://oig.justice.gov/reports/2018/e1901.pdf.

[7] The undercount of deaths due to COVID is not simply a problem in federal prisons and immigration detention. See Maura Turcotte, et al., *The Real Toll From Prison Covid Cases May Be Higher Than Reported*, The New York Times, (July 7, 2021), available at https://www.nytimes.com/2021/07/07/us/inmates-incarcerated-covid-deaths.html, (noting that "The New York Times identified dozens of people who died … but were not included in official counts" of detainees who died of COVID-19).

[8] *See* UCLA Law COVID Behind Bars Data Project, *The Federal Bureau of Prisons is Even Less Transparent Than We'd Thought*, (Apr. 2, 2021), available at https://uclacovidbehindbars.org/blog/bopdata.

[9] *Id.*

the BOP data and realized that BOP had been engaged in this data scrubbing since October 2020. The UCLA team noted that

> This reporting practice is disturbing because it obscures the true toll of the coronavirus in federal prisons. Without a true cumulative case count, it is extremely difficult for observers to track the incidence rate — the rate over time — of COVID-19 infection among the federal prison population. This incidence rate is important for understanding the risk of infection that individuals face while incarcerated and for evaluating the BOP's response. With the BOP's data as reported, we can only calculate "point prevalence" — the infection rate among the population at a specific point in time.[10]

The lack of transparency from BOP related to its data reporting practices related to COVID infection rates also necessarily calls into question the accuracy of any data reported (publicly or to BJA pursuant to DCRA) of deaths in federal prison custody due to COVID-19.

2. ICE / CBP Practices

Hidden deaths are also a serious issue for people held by the Department of Homeland Security ("DHS"), including ICE and CBP detention. We encourage the subcommittee to investigate and analyze the practices of DHS and its contractors in covering up the deaths of immigrants in its custody. For years, media reports have documented multiple occasions on which DHS has released detained immigrants from custody on their deathbeds, without reporting or disclosing these deaths.[11] This deeply

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[10] *Id.*

[11] *See, e.g.,* Andrea Castillo and Jie Jenny Zou, *ICE Rushed to Release a Sick Woman, Avoiding Responsibility for Her Death. She Isn't Alone*, Los Angeles Times (May 13, 2022), available at https://www.latimes.com/world-nation/story/2022-05-13/ice-immigration-detention-deaths-sick-detainees; Dan Glaun, *How ICE Data Undercounts COVID-19 Victims*, PBS FRONTLINE (Aug. 11, 2020), available at https://www.pbs.org/wgbh/frontline/article/how-ice-data-undercounts-covid-19-victims/; Amy Taxin, *Family Seeks Answers in Immigrant's Death after Detention*, AP News, Apr. 10, 2019, https://apnews.com/article/immigration-us-news-ap-top-news-caribbean-california-8775303f79ee4d44a5959c34a8f3d99d; Adolfo Flores, *A Transgender Woman Died After Being Held For Weeks In ICE Custody*, BuzzFeed News, June 3, 2019, https://www.buzzfeednews.com/article/adolfoflores/transgender-woman-dies-ice-custody-asylum; Sam Levin, *Trans Woman Who Died after Illness in US Custody Had Asked to Be Deported, family says*, The Guardian, June 12, 2019, https://www.theguardian.com/us-news/2019/jun/12/trans-woman-death-us-custody-ice-deportation; William Thornton, *"One Who Could Have Been You": Group Protests Former Detainee's Death*, Advance Local, Feb. 28, 2016 (updated Jan. 13, 2019),

troubling practice is consistent with reports of ICE's "culture of secrecy."[12] The ACLU is aware of several deaths in the past decade that occurred immediately after people were released from ICE's custody while hospitalized:

- Martin Vargas Arellano, a 55-year-old with diabetes, hypertension, gout, and hepatitis C, was detained at an ICE facility in Adelanto, California in 2020. He contracted COVID-19 and suffered a stroke in ICE detention and was released from custody while hospitalized, three days before his death. ICE therefore did not count his death as a "death in custody." A federal judge has already noted that ICE's communications regarding his death appeared to "actively conceal" information and raised "significant concerns regarding the Government's actions and lack of candor."[13]
- Jose Ibarra Bucio, a 27-year-old man was also detained at the ICE facility in Adelanto, where he suffered a brain hemorrhage while detained and fell into a coma. He was transferred to a local hospital and was formally released from ICE's custody two weeks later. He died four weeks after his release from custody, when his family removed him from life support.
- Johana Medina Leon, 25-year-old transgender asylum seeker detained at an ICE facility in Otero County, New Mexico in 2019. While in custody she complained of health issues for a month and tested positive for HIV. After seven weeks in custody, she complained of chest pains and was taken to the hospital, at which point, ICE released her from custody. She died four days later of pneumonia.
- Teka Gulema, an Ethiopian man detained at an ICE facility in Gadsden, Alabama between 2012 and 2015, where he was paralyzed following a bacterial infection and transferred to a hospital, but remained in ICE custody for a year. But when he fell into a coma in the hospital, he was released from ICE custody, and died weeks later.

None of these people were counted as deaths while in the custody of ICE. With no reporting mechanism for deaths of people who were released from ICE and CBP detention while hospitalized, there may be significantly more of these hidden deaths. The

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https://www.al.com/news/anniston-gadsden/2016/02/one_who_could_have_been_you_gr.html.

[12] Nina Bernstein, *Officials Hid Truth of Immigrant Deaths in Jail*, The New York Times, Jan. 9, 2010, https://www.nytimes.com/2010/01/10/us/10detain.html (describing evidence obtained through FOIA requests showing officials "used their role as overseers to cover up evidence of mistreatment, deflect scrutiny," and "prepare exculpatory public statements after gathering facts that pointed to substandard care or abuse").

[13] Order, *Roman v. Wolf*, ED CV 20-00768 TJH, Dkt. 1031, (C.D. Cal. Mar. 20, 2021). In that case, the federal district court earlier held that ICE violated detainees' constitutional rights at the Adelanto facility based on "detailed factual findings" of the facility and staff taking inadequate precautions to protect detainees from the coronavirus. *Roman v. Wolf*, No. 20-55436, 2020 WL 5683233, at *4 (9th Cir. Sept. 23, 2020).

Committee should investigate the deaths listed above, and it should obtain documents from DHS and its Office of the Inspector General regarding the circumstances around the deaths, the decisions to release these people while they were hospitalized, and any investigations into these deaths. The Committee should also investigate whether there have been any additional deaths within the past decade of people who were officially released from DHS custody while hospitalized. Finally, the Committee should investigate ICE and CBP protocols and standards for determining whether to release people from custody while hospitalized and for reporting the deaths of people released from custody while hospitalized. ICE and CBP should be held accountable for these hidden deaths in its custody, and its policies must change to ensure it will be accountable for all deaths attributable to its detention network in the future.

B. Deaths in Police / Law Enforcement Custody

In addition to deaths that occur in jails and prisons, DCRA requires reporting on deaths in police custody. 34 U.S.C. § 60105(a) (requiring reporting on "the death of any person who is detained, under arrest, or is in the process of being arrested . . ."). Without full implementation of DCRA, public information about these deaths is limited. Recent estimates attribute more than 1,000 killings per year to the police, [14] and research suggests that more than half of police killings are not reflected in official statistics.[15] Police killings are an urgent crisis and one that disproportionately affects Black, Latino, and Native American people.[16] For example, Black people are killed by police at a rate more than twice as high as the rate for white people.[17] In too many jurisdictions around the country, police departments are insufficiently accountable to the people from whom they derive their power. Accountability cannot exist without comprehensive and reliable information, particularly information about how many people die in police custody and under what circumstances. Implementation of DCRA is therefore a critical step towards holding police departments accountable for their actions.

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[14] *See* Julie Tate, et al., *Fatal Force*, The Washington Post, https://www.washingtonpost.com/graphics/investigations/police-shootings-database/ (last accessed Sept. 19, 2022); Marisa Iati et al., *Fatal police shootings in 2021 set record since The Post began tracking, despite public outcry*, The Washington Post (Feb. 9, 2022), https://www.washingtonpost.com/investigations/2022/02/09/fatal-police-shootings-record-2021/; *Mapping Police Violence*, Campaign Zero, https://mappingpoliceviolence.org/ (last accessed Sept. 19, 2022).

[15] Tim Arango & Shaila Dewan, *More than half of police killings are mislabeled, new study says*, The New York Times (Sept. 30, 2021), https://www.nytimes.com/2021/09/30/us/police-killings-undercounted-study.html.

[16] *Id.*

[17] Tate, *Fatal Force*; Arango, *More than half of police killings are mislabeled, new study says*; Campaign Zero, *Mapping Police Violence*.

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We thank the Subcommittee for considering and including our comments on this important topic. Should you have any questions, please contact National Prison Project Deputy Directors Corene Kendrick or Tammie Gregg at ckendrick@aclu.org and tgregg@aclu.org.

Statement Of
The Leadership Conference on Civil and Human Rights
And
The Project On Government Oversight

United States Senate
Committee on Homeland Security and Government Affairs
Permanent Subcommittee on Investigations

"Uncounted Deaths in America's Prisons and Jails: How the Department of Justice Failed to Implement the Death in Custody Reporting Act"

September 20, 2022

Chairman Ossoff, Ranking Member Johnson, and Members of the Subcommittee: Thank you for your attention to the Death in Custody Reporting Act (DCRA) and the Department of Justice's (DOJ) ongoing failure to implement this important law. There is no doubt that there is a crisis of deaths in custody in this country, and that Black and Brown people are disproportionately the victims of violence, abuse, and neglect at the hands of the criminal-legal system. Due to DOJ's failure to implement DCRA, there is no single, comprehensive source of data on the number and circumstances of deaths in custody in the United States. This information vacuum deprives policymakers of crucial data to develop policies aimed at reducing these deaths.

Over the last four years, The Leadership Conference and the Project On Government Oversight (POGO), as well as many other organizations, have sent letters, written articles, and met with the DOJ and congressional offices to highlight the urgent need for action on DCRA.[1] As the Subcommittee's investigation and hearing have made clear, however, DOJ continues to fail to collect meaningful data. This statement draws from past advocacy and a forthcoming report by The Leadership Conference and POGO on DCRA to highlight four of the most glaring shortcomings in the DOJ's approach to the law, as well as outlining a meaningful path forward.

[1] See, for example, Letter to Attorney General Jeff Sessions from public interest organizations regarding DCRA implementation notice (September 28, 2018), https://www.aclu.org/sites/default/files/field_document/dcra_sign_on_9-28-18.pdf; Letter to Laura Wyckoff from Brandon Brockmyer and David Janovsky regarding DCRA collection notice (August 27, 2021), https://docs.pogo.org/letter/2021/DCRA-open-comment-letter.pdf?_ga=2.89016339.906268902.1659969457-1458519903.1659969457.

A Flawed Approach

DOJ has shown conflicting approaches to interpreting the scope of DCRA's mandate since the law's passage. DOJ's current plan reflects a narrow reading of DCRA.[2] It requires covered jurisdictions to report data on deaths in custody, but it does not commit to validating that data, requiring iterative improvements to collection efforts, or making data available to the public.

We believe this narrow approach undermines the spirit of DCRA, and may in fact prevent the department from fully complying with the statute's research and policy analysis requirements. It is likely that this approach will lead to incomplete and inaccurate data, making it impossible to meaningfully study deaths in custody or propose ways to reduce them.

A more robust approach is found in DOJ's since-abandoned 2016 implementation plan.[3] That plan included a number of provisions that are not explicitly required by the statute but significantly increase the likelihood that the program will be successful, including data validation, procedures to review and improve collection plans, and a proactive release of anonymized data so that the public can engage in the effort to understand and reduce deaths in custody.

In this statement, we recommend an implementation plan based on that 2016 proposal. We also recommend several technical measures to improve the comprehensiveness and utility of the data DOJ collects.

Challenges to Address

Most of our recommendations address four key areas where DCRA implementation can and should be improved: compliance, data collection methods, research scope, and transparency.

Compliance

DCRA cannot successfully serve its purpose if the agencies and jurisdictions that are required to report data fail to do so without consequence. To date, it appears that there have been issues gathering data from all required sources at both the federal and state levels. And DOJ's decision to not impose the statutory penalty of withholding up to 10 percent of a state's federal justice-related funding from non-compliant states, and its failure to set forth clear guidance for when and how it will be imposed, are missed opportunities to use the full scope of statutory compliance tools.

At the federal level, the Office of the Inspector General (OIG) reported that, as of 2018, DOJ was

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[2] "Agency Information Collection Activities; Proposed eCollection eComments Requested; Death in Custody Reporting Act Collection," 86 Fed. Reg. 50375 (proposed September 8, 2021), https://www.federalregister.gov/documents/2021/09/08/2021-19400/agency-information-collection-activities-proposed-ecollection-ecomments-requested-death-in-custody.

[3] "New Collection: Death in Custody Reporting Act Collection," 81 Fed. Reg. 91948 (proposed December 19, 2016), https://www.federalregister.gov/documents/2016/12/19/2016-30396/agency-information-collection-activitiesproposed-collection-comments-requested-new-collection-death.

still unsure of the number of federal agencies even covered by DCRA.[4] We do not know the status of internal efforts to determine that number, but defining the universe of covered agencies is an essential prerequisite to full compliance.

At the state level, we recognize that the statute places the burden of collecting data from local departments on each state, creating a patchwork of collection plans and several layers of reporting relationships. Because no data from the state collection has been released yet, we cannot know whether compliance is adequate. However, we are concerned that DOJ's current effort does not adequately support or oversee state collections. For instance, it does not require states to submit collection plans or improve those plans over time.

Again, DCRA gives the U.S. Attorney General the discretion to withhold up to 10 percent of a state's funding under the Byrne Justice Assistance Grant program and related funding sources. We recognize concerns that the compliance mechanism of a 10 percent grant reduction to a state's grant allocation is a blunt tool, as that particular money may or may not affect all local agencies. However, as the penalty has not been imposed yet, we have been unable to gauge its effectiveness. While it is true that the state-level penalty may not give every local agency a financial incentive to comply with the reporting requirement, it may be a sufficient incentive for states to leverage their own power over local jurisdictions to ensure compliance.

Data Collection

In addition to compliance, the methodological weaknesses in *how* data are currently collected would lead to such poor data quality as to jeopardize its usefulness.

The DCRA data collection instruments are forms designed for agencies and respondents to use to capture and report the DCRA data. The Bureau of Justice Assistance (BJA) uses one form for state deaths; the Bureau of Justice Statistics uses two forms for federal deaths (for deaths during arrests and in corrections custody).[5] Inconsistencies between these forms and changes to the forms over time cause data integrity issues. For example, if questions change from year to year, it is difficult to compare data over time. Additionally, if the forms ask substantively similar questions in different ways, it becomes more difficult to compare data collected from different forms.

More fundamentally, the current forms are insufficient for capturing all the information necessary to address the research questions mandated in DCRA. For example, on BJS Form CJ-

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[4] U.S. Department of Justice Office of the Inspector General, *Review of the Department of Justice's Implementation of the* Death in Custody Reporting Act of 2013," No. 19-01 (December 2018), 7, https://oig.justice.gov/reports/2018/e1901.pdf.

[5] Bureau of Justice Assistance, "Death in Custody Reporting Act Performance Measurement Questionnaire," OMB No. 1121-0365 (2019), https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/DCRA-Performance-Measure-Questionnaire_508.pdf;
Bureau of Justice Statistics, "Arrest-Related Death Incident Report," Form CJ-13A (2021), https://www.doj-dcra.org/pdfs/FDCRP_CJ-13A_fillable%20PDF%20FY2021_final.pdf?pdf=FDCRP_CJ-13A_fillable%20PDF%20FY2021_final;
Bureau of Justice Statistics, "Detention or Incarceration Death Incident Report," Form CJ-13B (2021), https://www.doj-dcra.org/pdfs/FDCRP_CJ-13B_fillable%20PDF%20FY2021_final.pdf?FDCRP_CJ-13B_fillable%20PDF%20FY2021_final.

13A, the 2016 and 2017 instruments required federal law enforcement agencies to report the number of officers who responded to the original service call, the number of officers discharging weapons, and the number of shots fired.[6] By 2018, these questions were deleted and as of 2021 had yet to be added back to the instrument.[7]

Between the 2018-2019 iterations and the 2021 iterations of BJS Form CJ-13B, multiple questions were dropped.[8] The dropped questions are critical for research, transparency, and accountability. They included questions about the existence and source of a death certificate; additional questions about people who died by suicide; additional injuries to personnel, other confined people, or the victim; law enforcement actions (e.g., use of a weapon); and, if the death was due to a preexisting medical condition, information on any medical treatment the decedent received.

The current form for the BJA state collection is also inadequate. The form requires very little data and reporting, especially when compared to the federal collection forms (CJ-13A and CJ-13B). Most notably, the BJA form omits questions regarding weapons used by the decedent and the officers/personnel; the reason for law enforcement use of force, injuries to law enforcement personnel and civilians; decedent behavior including types of resistance; or the decedent's perceived state of mind. Instead, the BJA form attempts to capture this in the qualitative text field with the following instructions: "Please provide a brief description of the circumstances leading to the death (e.g., details surrounding an event that may have led to the death, the number and affiliation of any parties involved in the incident, the location and characteristics of an incident, other context related to the death, etc.)."

This meets the statutory requirement to collect "a brief description of the circumstances" surrounding deaths. However, this open-ended approach runs the risk that not all relevant information will be captured and complicates subsequent data analysis by using text rather than checkboxes.

All these inconsistencies in data collection harm data integrity and usability. The inconsistent wording of questions across years diminishes our ability to compare trends or agency types. This also applies to comparisons between federal, state, and local agencies. The result of these challenges is a likelihood that the department will be unable to use the data to answer the statutorily mandated research questions.

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[6] Bureau of Justice Statistics, "Arrest-Related Death Incident Report," Form CJ-13A (2016), https://bjs.ojp.gov/content/pub/pdf/CJ-13A2016.pdf; Bureau of Justice Statistics, "Arrest-Related Death Incident Report," Form CJ-13A (2017), https://bjs.ojp.gov/content/pub/pdf/CJ-13A2017.pdf.

[7] Bureau of Justice Statistics, "Arrest-Related Death Incident Report," Form CJ-13A (2018-2019), https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/survey/cj13a_2018-2019.pdf; Bureau of Justice Statistics, "Arrest-Related Death Incident Report," Form CJ-13A (2021), https://www.doj-dcra.org/pdfs/FDCRP_CJ-13A_fillable%20PDF%20FY2021_final.pdf?pdf=FDCRP_CJ-13A_fillable%20PDF%20FY2021_final.

[8] Bureau of Justice Statistics, "Detention or Incarceration Death Incident Report," Form CJ-13B (2018-2019), https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/survey/cj13b_2018-2019.pdf; Bureau of Justice Statistics, "Detention or Incarceration Death Incident Report," Form CJ-13B (2021), https://www.doj-dcra.org/pdfs/FDCRP_CJ-13B_fillable%20PDF%20FY2021_final.pdf?FDCRP_CJ-13B_fillable%20PDF%20FY2021_final.

Another challenge to compliance and collecting quality data is that collection methods likely vary by state. With these different methods of collection, it may be methodologically unsound to compare data from different states.

Finally, the track record of the BJS Arrest Related Deaths program suggests that relying solely on self-reported data will likely result in undercounts.[9] While we recognize that the plain language of DCRA only requires the department to collect data from state reporting agencies and federal agencies, some sort of audit using open source data is necessary to ensure the collection program is working and will be an essential aspect of data collection for DOJ to satisfy the research requirements in the statute.

Research Scope

The DCRA of 2013 mandates that DOJ answer two broad research questions.[10] The first is to analyze how to use the data collected to reduce the number of deaths in custody. The second is to find relationships, if any, between deaths in custody and administrative policies. But there are no data collection plans that would produce the information necessary to deliver on this requirement. Most notably, answering these questions requires an analysis of agency and facility policies, such as those pertaining to use of force. These policies change over time and vary across agencies and departments. To obtain the data necessary to conduct an accurate and relevant analysis of the impact of policies on deaths, data collection on agency policies would have to be essentially ongoing. Based on the data currently being collected at this time, DOJ will be unable to fulfill the research requirement outlined in the statute.

Transparency

The DCRA statute does not explicitly require the public release of data beyond the report to Congress. However, the spirit of the law is plainly to increase public understanding of deaths in custody. This congressional intent is reflected most recently in the Senate Appropriations Committee's preliminary explanatory report accompanying the 2023 Commerce, Justice, Science, and Related Agencies appropriations bill, which calls on the department to provide an explanation of how to "improve the quality and transparency of future data collected" under DCRA.[11]

It is true that other federal laws, like the Privacy Act, limit how the government handles individually identifying information, and we understand that OJP is concerned about privacy when it comes to releasing DCRA data to the public.[12] While we appreciate the constraints

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[9] Duren Banks, Lance Couzens, and Michael Planty, Bureau of Justice Statistics, *Technical Report: Assessment of Coverage in the Arrest-Related Deaths Program,* NCJ 249099 (October 2015), 1, https://bjs.ojp.gov/content/pub/pdf/acardp.pdf.

[10] 34 U.S.C. § 60105(f)(1)-(2), https://www.law.cornell.edu/uscode/text/34/60105.

[11] Senate Appropriations Committee, "Explanatory Statement for Commerce, Justice, Science, and Related Agencies Appropriations Bill, 2023," Title II, 79, https://www.appropriations.senate.gov/imo/media/doc/CJSFY23RPT.PDF.

[12] The Privacy Act, 5 U.S.C. §552a, limits how agencies handle "records" pertaining to individuals, defined as "any item, collection, or grouping of information about an individual that is maintained by an agency, including, but not limited to, his education, financial transactions, medical history, and criminal or employment history and that contains his name, or the identifying number, symbol, or other identifying particular as- signed to the individual, such as a finger or voice print or a photograph."

imposed by other laws, we do not agree that they are a major stumbling block to the release of ideally incident-level data, but at least agency- and facility-level data. As the department acknowledged in its 2016 plan, removing individually identifying information should resolve Privacy Act concerns, making it possible to release at least agency- and facility-level data. The identities of agencies that report deaths in custody are not protected by privacy considerations. And BJA, as a non-statistical agency, does not face the same restrictions on the use and aggregation of data as BJS does.

The federal data tables BJS currently releases are insufficient for the purpose of enabling true public engagement with the information. To determine how the data may help reduce deaths in custody, stakeholders and outside researchers will need more granular data than what has been released to date. The basic data tables prevent a fuller understanding of the context of each incident and the discovery of overall patterns in the data. Because the data are aggregated and presented at a national level, we cannot use them to analyze the relationships of variables within the data. As an example, the BJS data tables cannot shed light on the racial breakdown of people placed in prone positions by law enforcement before their death, because the tables only sort by one variable at a time.

Sources for Reform

Many of our recommendations are derived from prior DOJ proposals and examples from other jurisdictions with death in custody reporting programs. We provide a brief overview to emphasize that roadmaps for DCRA improvement already largely exist.

2016 DCRA Collection Plan

The first proposal from BJA for state data collection was announced in the Federal Register on December 19, 2016. It remains the most detailed and rigorous plan for implementing DCRA and still provides a model for how the department could realize both the spirit and letter of the law.[13] The most notable features of the 2016 plan include:

- Precise definitions of deaths that must be reported.
- A requirement for states to develop and submit plans for collecting the data they are required to report to the department. Those plans were to be reassessed annually to ensure their effectiveness.
- A plan for the department to use open-source data to evaluate the accuracy of data reported by states, modeled on the BJS redesign of the Arrest Related Deaths program.[14]
- A commitment to release anonymized data at the agency and facility level.

Crucially, the plan shows that the department itself has previously endorsed actions that would broadly address many of the concerns we raise in this statement. Readopting them would not require breaking new ground.

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[13] "Agency Information Collection Activities; Proposed Collection Comments Requested; New Collection: Death in Custody Reporting Act Collection", 81 Fed. Reg. 91948 (December 19, 2016), https://www.federalregister.gov/documents/2016/12/19/2016-30396/agency-information-collection-activities-proposed-collection-comments-requested-new-collection-death.

[14] Bureau of Justice Statistics, *Technical Report: Arrest-Related Deaths Program: Pilot Study of Redesigned Survey Methodology*, NCJ 252675 (July 2019), https://www.bjs.gov/content/pub/pdf/ardppsrsm.pdf.

State Efforts: Texas Death in Custody Act of 1983
DOJ has an important role to play in sharing best practices with states. However, several states have practices that may help inform federal efforts as well.

The Texas DCA of 1983 requires law enforcement agencies in the state to report deaths in custody which includes deaths occurring during physical detainment, arrest, and incarceration.[15] These reports are submitted to the office of the state attorney general and are due within 30 days of the death.

The Texas office of the attorney general currently posts information from *each individual death* in custody to its website, amounting to more than 15,000 entries dating back to the early 1980s.[16] This, in turn, has enabled non-governmental organizations to create interactive data visualizations.[17]

In recent years, journalists and advocates have pointed out weaknesses in the implementation of the Texas law. In a five-year period since 2015, hundreds of reports were filed after the 30-day limit, and more than 100 reports lacked required medical examiner information.[18] The punishment for failing to comply is a class B misdemeanor and could potentially result in up to 180 days in jail. However, like the federal DCRA, this punishment has never been levied.[19]

Even with these issues, the Texas program provides an example of how to make data on deaths in custody relatively available to the public and how additional transparency can highlight challenges and lead to improvement in data collection processes.

Other State Efforts
California collects data on deaths in custody pursuant to Government Code § 12525, first passed in 1961.[20] Again, in-custody deaths are more broadly defined in this state context to include deaths during any type of detainment, including during arrest. California also creates visualizations so the public can better understand the trends in the data.[21] Additional states like Illinois passed state laws that require all law enforcement agencies to report deaths in custody.[22]

The DCRA has also encouraged states to be more transparent about deaths in custody even when the state has not passed its own law. For example, the Indiana Criminal Justice Institute (ICJI) is

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[15] Tex. Code Crim. Proc. art. 49.18.
[16] "Custodial Death Report," Office of the Attorney General of Texas, https://oagtx.force.com/cdr/cdrreportdeaths.
[17] Amanda Woog, *Texas Custodial Death Report: Police, jail, and prison deaths 2005-2015*, Texas Institute of Justice (July 2016), https://texasjusticeinitiative.org/static/2016TJIReport.pdf.
[18] David Barer and Josh Hinkle, "Dead and Undone," KXAN, November 23, 2020, https://www.kxan.com/dead-in-custody/.
[19] David Barer, "Bill to reform reporting of deaths in custody faces law enforcement opposition," KXAN, April 21, 2021, https://www.kxan.com/investigations/bill-to-reform-reporting-of-deaths-in-custody-faces-law-enforcement-opposition/.
[20] Cal. Gov. Code § 12525
[21] California Department of Justice, "Death in Custody 2011-2020," archived at https://web.archive.org/web/20220427021054/https://openjustice.doj.ca.gov/data-stories/deathincustody. The California DOJ Open Justice website has been down for several months after a breach of unrelated data.
[22] 730 Ill. Comp. Stat. § 210/3-5, https://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=4075&ChapterID=55.

the state statistical agency responsible for collecting DCRA data. In March 2021, the ICJI released a report covering 2020 data, and subsequently created an online statistical dashboard.[23] These efforts make it easier to understand patterns that could be lost when data are aggregated at the national level. Simple visualizations combined with the reporting requirements of the DCRA give advocates and researchers another opportunity to monitor deaths in custody within a state.

Recommendations

As we look at existing statutes and current systems for reporting, our recommendations below are straightforward, within the already existing statutory framework, and will dramatically improve the accessibility and usefulness of DCRA reporting.

DCRA Administration

- Refine and update coordination, definitions, and guidance for data collectors at the federal and state levels. This consistent attention to updated, clear, standardized guidance and collaborative technical assistance will positively impact compliance, data collection, research, and transparency.
- Go beyond the plain text of the statute in designing a DCRA implementation plan. The 2016 plan illustrates how steps beyond those explicitly described in the law are necessary to fully realize the stated requirements and underlying intent of DCRA.
- If it does not exist already, we recommend a mechanism for state and local personnel to provide feedback on training and guidance so that the BJA may iteratively improve these resources.

Compliance

First, every local, state, and federal agency with arrest or custodial authority must participate fully in data collection and reporting. The power to arrest and detain people demands a companion responsibility to do so with integrity. Collecting and reporting quality data is the mechanism for ensuring integrity. Compliance cannot be optional. However, to avoid the risk that imposing the penalty will make it harder for states to fund compliance, DOJ should readopt the provision from the 2016 plan allowing states to use the 10 percent that would be penalized to fund DCRA implementation.

- Use all available data, including from open sources, to assess compliance. Full compliance requires reporting complete and accurate information, which cannot be known without some sort of audit.
- Issue clear standards for when and how the 10 percent penalty will be imposed. Impose the penalty on non-compliant states.
- Give states the option to use the 10 percent that would otherwise be withheld to improve and standardize data collection and reporting processes.

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[23] Kaitlyn Christian, "2021 Annual Report: Death in Custody Reporting Act," Indiana Criminal Justice Institute (March 2021), https://ncvc.dspacedirect.org/bitstream/handle/20.500.11990/2743/REPORT_Death-in-Custody-Reporting-Act-Annual-Report.pdf; Indiana Criminal Justice Institute, "Death in Custody Reporting Act (DCRA) Data," https://datavizpublic.in.gov/views/DeathinCustodyReportingActDCRADashboard/DCRADashboard?%3AshowAppBanner=false&%3Adisplay_count=n&%3AshowVizHome=n&%3Aorigin=viz_share_link&%3Aiid=1&%3AisGuestRedirectFromVizportal=y&%3Aembed=y.

Data Collection Methods

Collection forms must be designed to collect the data we need to answer the critical questions at hand. This requires re-engineering the forms with purpose, intent, and technical expertise. We cannot collect inferior data and expect quality research as a result. The two are mutually exclusive. To this point, we recommend a more robust data collection plan modeled largely after the December 2016 collection plan. Critical components of the 2016 plan include clear and robust definitions and annual state-level data collection plans. Additionally, the BJA and the BJS should collaborate to create uniform forms across programs and departments that can be used for several years.

- Redesign federal and state forms so that:
    - Demographic variables for race, ethnicity, and age brackets match the U.S. Census Bureau classifications for easy comparability and use. Going forward, DCRA forms should always be updated to reflect any future adjustments to the U.S. Census classifications. Getting DCRA collection on the census standard for race could have positive implications for other law enforcement collections at the federal, state, and local levels.
    - Questions relevant to arrest-related and in-custody deaths should appear on both collection forms.
    - Questions shared by both forms should have identical wording and answer sets.
    - To the extent possible, questions should be specific with check box or multiple-choice answers.
    - Ensure forms capture killings by law enforcement officers as a separate category, rather than capturing these deaths in an "other" category.
    - Keep the text box with a clear prompt on the incident report forms.
    - All forms should include one question at the end of the survey with an open text box answer where additional details about the death in custody can be reported. However, the forms should not rely on text boxes as the primary or only means of eliciting key information.
    - Ensure that the forms also capture deaths of bystanders that are a consequence of police action.
    - Structure questions about cause of death that clearly distinguish between accidents and intentional deaths.
- Once the forms are redesigned, keep them consistent over several years. Additions can be made, but standardized questions and answers between forms should be kept the same for research and evaluation.
- When changes to forms are needed, first study how changes would affect the quality of data. This is a typical practice for federal agencies like the U.S. Census Bureau, and we recommend that steadied approach here.
- Restore the 2016 requirement for states to submit data collection plans and review and revise those plans annually.

Research Scope

The U.S. Attorney General must commit to studies that address the DCRA-mandated research questions. In order to facilitate this, it must clearly define the universe of data necessary to answer those questions. We recommend the December 2016 definitions as a model to help define reportable deaths, as it provides specific and granular categories of covered situations. DCRA

data collection must also address the fundamental issue of policy data collection to satisfy the second part of the DCRA-mandated research.

- Identify the most appropriate definition of deaths to include in the DCRA reporting. Use this definition consistently across agencies, forms, and years. We recommend the definition used in the December 2016 data collection plan.
- Develop a plan to gather data on relevant agency and facility policies.
- When an investigation is open/pending at the time the data are reported, create a process for respondents to follow up after the investigation is closed and report required data.

Transparency

DOJ and other federal agencies must commit to timely data reporting. As a good faith effort, we recommend the responsible agencies release more data now. Specifically, publish homicides broken out by use-of-force/police-involved and other homicides — a step taken for the first time in the July 2022 data tables published by BJS.[24] Release the existing data at a more granular level by agency, facility, and perhaps even at the level of individual incidences in machine readable formats.

- Create, maintain, publicly publish, and annually update a list of federal agencies subject to the DCRA.
- Where applicable, clarify whether deaths occurred in agency-owned facilities or contract facilities.
- Improve data reporting with more visual reports and public data dashboards.
- Create a unique individual identifier (a number) system like those commonly used by other agencies to protect privacy while disaggregating data for research and evaluation.

Publicly accessible data on deaths in custody is an essential aspect of law enforcement accountability in the United States. We need accurate data to research in custody deaths and learn how to prevent them. Without sound DCRA implementation, decisionmakers do not have the information they need to make policy, advocates do not have a clear picture of the full impact of the criminal-legal system, and DOJ cannot provide the oversight needed to reduce in custody deaths. The recommendations made in this report will strengthen DCRA administration and compliance, improve data collection, expand the ability to conduct DCRA required research and increase transparency.

[24] Connor Brooks and Sean E. Goodison, *Federal Deaths in Custody and During Arrest, 2020 – Statistical Tables*, Bureau of Justice Statistics NCJ 304939 (July 2022), 4, https://bjs.ojp.gov/content/pub/pdf/fdcda20st.pdf.

Questions for the Record
Submitted to Maureen A. Henneberg
Deputy Assistant Attorney General for Operations and Management
Office of Justice Programs
U.S. Department of Justice
Hearing Before the Senate Homeland Security and Governmental Affairs
Permanent Subcommittee on Investigations
"Uncounted Deaths in America's Prisons and Jails: How the Department of Justice Failed to Implement the Death in Custody Reporting Act"
September 20, 2022

Ranking Member Ron Johnson

1. **Please provide the total number of employees currently employed at the Bureau of Justice Statistics.**

RESPONSE: The total number of current full-time employees at the Bureau of Justice Statistics (BJS) is 55. Those employees work on a variety of statistical collections and analyses on crime, criminal offenders, victims of crime, and the operation of justice systems at all levels of government. For more information see https://bjs.ojp.gov/.

2. **Please provide the total number of employees currently employed at the Bureau of Justice Assistance.**

RESPONSE: The total number of current full-time employees at the Bureau of Justice Assistance (BJA) is 131. Those employees work on a variety of programs and initiatives to strengthen the nation's criminal justice system and help America's state, local, and tribal jurisdictions reduce and prevent crime, reduce recidivism, and promote a fair and safe criminal justice system. For more information see https://bja.ojp.gov.

3. **Please provide the total number of employees:**
   a. **Working full time on implementation of the Death in Custody Reporting Act as of September 20, 2022; and**
   b. **Working part-time on implementation of the Death in Custody Reporting Act, including the percentage of each workday spent on any such work, as of September 20, 2022.**

RESPONSE:

As of September 20, 2022—

- BJS employs two statisticians who split Death in Custody Reporting Act (DCRA) duties among other duties, and the equivalent of 0.5 full-time contractors working on DCRA. These individuals work on collection of federal agency information required under DCRA.

- BJA employs three staff members and six contract staff, all of whom split work on DCRA issues among other duties. The contract staff comprise the equivalent of approximately two contract FTE to include: one task lead, two deputy task leads (one for TTA and one for data collection, research, and analysis), one senior research analyst, one research analyst, and one TTA specialist.

- In addition, the BJA Performance Measurement Tool (PMT) Helpdesk provides DCRA-related support which has recently increased due to a rise in DCRA-related requests for assistance, as well as state-level outreach to facilitate data cleaning. The PMT Helpdesk provides support for programs across OJP with the equivalent of four contract FTEs. Of those, the equivalent of 2.5 contract FTE are devoted to the Helpdesk for BJA specifically.

The Office of Justice Programs has committed to increasing the resources dedicated to DCRA, including the following: (1) currently hiring one FTE at BJA fully dedicated to DCRA; (2) providing time commitment from one senior staff person at BJS who is consulting with BJA on data collection and analysis; and (3) creating a senior statistician position at BJS who will devote time to DCRA-related issues. In addition, BJA is bringing on board two FTE contractors, and BJA and BJS are each bringing on board an outside expert through the Intergovernmental Personnel Act (IPA), who will be dedicated full time to DCRA issues.