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DEATH IN CUSTODY REPORTING ACT OF 2007

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

ON

H.R. 2908

JULY 24, 2007

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DEATH IN CUSTODY REPORTING ACT OF 2007

TUESDAY, JULY 26, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIME, TERRORISM,
AND HOMELAND SECURITY
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 1:49 p.m., in Room 2141, Rayburn House Office Building, the Honorable Robert C. "Bobby" Scott (Chairman of the Subcommittee) presiding.

Present: Representatives Scott, Waters, Delahunt, Johnson, Davis, Baldwin, Forbes, Sensenbrenner, Coble, and Chabot.

Staff present: Bobby Vassar, Subcommittee Chief Counsel; Gregory Barnes, Majority Counsel; Mario Dispenza, Majority Counsel; Veronica L. Eligan, Professional Staff Member; Michael Volkov, Minority Counsel; and Caroline Lynch, Minority Counsel.

Mr. SCOTT OF VIRGINIA. The Subcommittee will now come to order.

I am pleased to welcome you today to the hearing before the Subcommittee on Crime, Terrorism, and Homeland Security on H.R. 2908, the "Death in Custody Reporting Act of 2007."

The hearing will focus on the rationale for reauthorizing the "Death in Custody Reporting Act of 2000," which expired on December 31, 2006. That bill had bipartisan support, created a uniform system for the reporting of deaths in law enforcement custody to the United States Department of Justice.

Although it is a preliminary conclusion and needs to be confirmed by research and analysis, it appears that the act has contributed to the decline in death rates among those in various categories of law enforcement custody.

Before the enactment of the "Death in Custody Reporting Act of 2000," states had no uniform requirements for reporting the circumstances surrounding the death of persons in custody. The lack of uniform reporting requirements made it impossible to ascertain the percentage of deaths by suicide and homicides or from natural causes, which, in turn, made oversight of the treatment of those in custody inadequate.

Consequently, an environment of suspicion arose surrounding over 1,000 deaths which were believed to have occurred in custody situations each year. Many of those that were ruled suicide or deaths from natural causes were suspected of being homicides committed either by officers or other prisoners.

However, the indifference to prisoners' rights and safeties of those in custody made scrutiny of suspected death the low priority and deaths of questionable cause were rarely investigated.

From the mid-1980's to the enactment of the "Death in Custody Reporting Act," researchers and activists scrutinized the death rate in the Nation's jails and prisons and found very little reporting of the circumstances surrounding the deaths. In fact, by 1986, only 25 States and the District of Columbia even had jail inspection units.

Moreover, even the States that did report deaths differed in basic reporting standards. Insufficient data and the lack of uniformity of the data collected made oversight of prisoner safety woefully inadequate.

However, the interest in oversight that emerged through the researchers and activists shed light on conditions in local and State jails, which began a rising tide of wrongful death litigation. The increasing litigation forced some measure of accountability and conditions somewhat improved.

Moreover, activism and news of litigation spurned media interest, which shed further light on the conditions.

The watershed moment of bringing death in custody rates to national attention occurred in 1995. After conducting a 1-year investigation into prison conditions and the death rate of prisoners in custody, the Asbury Park Press of New Jersey ran a series of award-winning editorials that brought the seriousness of the lack of reporting to the Nation's attention.

The editorials went on to detail abuses, including racism, overzealous police interrogations, cover-up and general police incompetence, which prompted Congressional action.

Following successive introduction of bills in several Congresses with my Republican colleagues from Arkansas, first, Representative Tim Hutchinson and then-Representative Asa Hutchinson, the "Death in Custody Reporting Act of 2000" was passed. The law required States receiving certain Federal funds to comply with the reporting requirements established by the attorney general.

Since the enactment of the act, the Bureau of Justice Statistics, the BJS, has compiled a number of statistics detailing not only the circumstances of prisoner death, but the rates of death in prisons versus jails and the rates of death based on the sizes of the various facilities.

With the detailed statistical data, policy-makers, both State and local, are able to make informed policy judgments about the treatment of persons in their custody, which has assisted in lowering the death rate. In fact, since the focus on death in custody emerged in the mid 19890's the latest BJS report, dated August 2005, shows a 64 percent decline in suicides and a 93 percent decline in the homicide rate.

To continue this success, this hearing will hear testimony as part of the consideration of whether to reauthorize Public Law 106-297 as the "Death in Custody Reporting Act of 2007."

[The bill, H.R. 2908, follows:]

I

110TH CONGRESS
1ST SESSION

H. R. 2908

To encourage States to report to the Attorney General certain information regarding the deaths of individuals in the custody of law enforcement agencies.

IN THE HOUSE OF REPRESENTATIVES

JUNE 28, 2007

Mr. SCOTT of Virginia introduced the following bill; which was referred to the Committee on the Judiciary

---

A BILL

To encourage States to report to the Attorney General certain information regarding the deaths of individuals in the custody of law enforcement agencies.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Death in Custody Reporting Act of 2007".

SEC. 2. INFORMATION REGARDING INDIVIDUALS WHO DIE IN THE CUSTODY OF LAW ENFORCEMENT.

(a) IN GENERAL.—For each fiscal year after the expiration of the period specified in subsection (b)(1) in which a State receives funds for a program referred to

in subsection (b)(2), the State shall report to the Attorney General, on a quarterly basis and pursuant to guidelines established by the Attorney General, 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) that, 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.

(b) COMPLIANCE AND INELIGIBILITY.—

(1) COMPLIANCE DATE.—Each State shall have not more than 30 days from the date of enactment of this Act to comply with subsection (a), except that—

(A) the Attorney General may grant an additional 30 days to a State that is making good faith efforts to comply with such subsection; and

(B) the Attorney General shall waive the requirements of subsection (a) if compliance with such subsection by a State would be un-

1 constitutional under the constitution of such
2 State.
3 (2) INELIGIBILITY FOR FUNDS.—For any fiscal
4 year after the expiration of the period specified in
5 paragraph (1), a State that fails to comply with sub-
6 section (a) shall not receive 10 percent of the funds
7 that would otherwise be allocated for that fiscal year
8 to the State under subpart 1 of part E of title I of
9 the Omnibus Crime Control and Safe Streets Act of
10 1968 (42 U.S.C. 3750 et seq.), whether character-
11 ized as the Edward Byrne Memorial State and Local
12 Law Enforcement Assistance Programs, the Local
13 Government Law Enforcement Block Grants Pro-
14 gram, the Edward Byrne Memorial Justice Assist-
15 ance Grant Program, or otherwise.
16 (c) REALLOCATION.—Amounts not allocated under a
17 program referred to in subsection (b)(2) to a State for
18 failure to fully comply with subsection (a) shall be reallo-
19 cated under that program to States that have not failed
20 to comply with such subsection.

○

Mr. SCOTT OF VIRGINIA. It is now my pleasure to recognize my Virginia colleague, the gentleman from Virginia's 4th Congressional District, the Ranking Member of the Subcommittee, Randy Forbes.

Mr. FORBES. Thank you, Chairman Scott. And I appreciate your leadership for many years on this important issue, and I support your efforts to monitor the rate of deaths in custody.

We have found common ground on the importance of continued oversight of Federal and State prisons. I am a strong advocate for tough penalties, particularly for violent offenders. The important goal of our criminal justice system can and should be pursued, while, at the same time, providing proper health-care services to prisoners.

I wish to extend a very special welcome to Ms. Mary Scott, who has graciously agreed to share her story with us today. Ms. Scott's son, Jonathan Magbie, died in the D.C. Correctional Treatment Facility in September 2004, 4 days into a 10-day jail sentence for possession of marijuana.

Jonathan was 4 years old when he was hit by a drunk driver, leaving him with limited to no use of his arms and no use of his legs. He suffered numerous ailments as a result of his injuries and required constant care. Sadly, Jonathan's death could have been prevented and should serve as an example for proper health care in Federal and State prison facilities.

The Bureau of Justice Statistics reports that there were 15,308 State prisoner deaths between 2001 and 2005. Likewise, there were an additional 5,935 local prisoner deaths and 43 juvenile deaths between 2000 and 2005. Between 2001 and 2004, half of all State prisoner deaths were the result of heart diseases and cancer. Two-thirds involved inmates aged 45 or older, and two-thirds were the result of medical problems which were present at the time of admission.

Although illness-related deaths have slightly increased in recent years, the homicide and suicide rates in State prisons have dramatically decreased over the last 25 years.

I look forward to hearing from today's witnesses about the significance of these trends, and I yield back the balance of my time.

Mr. SCOTT OF VIRGINIA. Thank you.

Without objection, other statements will be placed into the record.

We have a very distinguished panel of witnesses today to help us consider the reauthorization of the "Death in Custody Reporting Act."

Our first witness will be Jeffrey Sedgwick, the director of the Bureau of Justice Statistics, where he oversees the collection of data required by the "Death in Custody Reporting Act." As a professor at the University of Massachusetts, Mr. Sedgwick has authored a number of articles on law enforcement, criminal justice policy and policy analysis. He has a B.A. degree from Kenyon College, an MAPA and Ph.D. from the University of Virginia. And after earning his Ph.D., he joined the University of Massachusetts faculty and is presently on leave from that position.

Our next witness will be Mr. Charles Sullivan, executive director and co-founder of the International Citizens United for Rehabilita-

tion of Errants, or CURE. CURE is a grassroots organization dedicated to reducing crime through reform of the criminal justice system. CURE was instrumental in passing the "Death in Custody Reporting Act" in the state of Texas in 1983. And after seeing the passage in Texas, Mr. Sullivan and CURE worked with Members of Congress toward a national reporting bill, which became the "Death in Custody Reporting Act of 2000." He has a bachelor's degree in philosophy from St. Mary's College and a master's in history from Notre Dame Seminary in New Orleans.

Our next witness is Ms. Jenni Gainsborough, director of the Washington office of Penal Reform International. PRI has officers throughout the world, developing and implementing programs to improve access to justice and to ensure the humane treatment of prisoners in accordance with the international human rights laws and standards. PRI also works to reduce the imprisonment through alternatives to incarceration and for the abolition of the death penalty. Prior to joining PRI in 2002, she was a senior policy analyst with the Sentencing Project. Before that, she was a public policy coordinator of the ACLU's national prison project. She began her career in criminal justice working with a Department of Justice program for serious habitual juvenile offenders. She has a B.A. in education in English from the University of London and an MBA from Pepperdine University in California.

And our final witness will be Ms. Mary Scott. She has approximately 35 years of Federal service and currently works for the Federal Government at the U.S. Army Human Resources Command in Alexandria. She is a mother of five children and several grandchildren. And one of her children, as the Ranking Member has indicated, was incarcerated in Washington, DC, and died shortly after his incarceration. Ms. Scott was born and raised in Washington, DC, and is a graduate of Theodore Roosevelt High School.

Now, each of our witnesses' written statements will be entered into the record in its entirety. I would ask each witness to summarize his or her testimony in 5 minutes or less.

And to help you stay within that time, there is a timing device on the table. When the light switches from green to yellow, you will have approximately 1 minute to conclude your testimony. And when the light turns red, it signals that the witness's 5 minutes have expired.

We will now begin with Mr. Sedgwick.

TESTIMONY OF JEFFREY SEDGWICK, DIRECTOR, BUREAU OF JUSTICE STATISTICS, OFFICE OF JUSTICE PROGRAMS, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, DC

Mr. SEDGWICK. Chairman Scott, Ranking Member Forbes and distinguished Members of the Committee, I am Jeffery Sedgwick, director of the Bureau of Justice Statistics.

BJS is the official statistical agency of the United States Department of Justice and a component of the Office of Justice Programs.

I am pleased to be here today to discuss the "Deaths in Custody Reporting Act."

The health and well-being of persons subject to the custody of law enforcement and correctional authorities is an important issue in criminal justice. Collecting and reporting data on deaths in cus-

tody is also an important part of the Office of Justice Programs' mission to improve the fair administration of justice across America and of the Bureau of Justice Statistics' mission to collect, process, analyze and disseminate accurate and timely information on crime and the administration of justice.

Mr. Chairman, BJS is committed to fulfilling the data collection and reporting provisions of DCRA. I am pleased to report that the Bureau has been successful in initiating the statistical activities of the Act.

As a result of BJS's comprehensive collection effort, there is 100 percent coverage of State prisons and over 99 percent coverage for local jails and state-operated juvenile systems.

Further, BJS developed the data collection covering State and local law enforcement agencies in more than 40 States. Between 2000 and 2005, the latest year for which complete data are available, BJS has collected and processed records on more than 15,000 deaths in State prisons, nearly 6,000 deaths in local jails, and 2,000 deaths in the process of arrest or transfer to detention.

Since the Act was passed, BJS has released two groundbreaking reports on deaths in custody, a special report on suicide and homicide in State prisons and local jails and a report on medical causes of death in State prisons. These reports offered the first opportunity to analyze the personal characteristics, current offenses and environmental factors surrounding the inmate deaths on a national scale.

While the first report highlighted sharp declines in suicide and homicide rates, it also provided important insights into the characteristics of persons most at risk of death, as well as knowledge of variations in death rates among systems and facilities.

The second report concerned medical causes of death in State prisons, giving Congress and the public the first detailed look into the physical health and characteristics of inmates whose death in custody was medically-related.

Though BJS has had tremendous success thus far in implementing the data collection provisions of DCRA, we face difficulties in obtaining information on deaths that occur in the process of arrest or in transit after arrest. To fully measure such deaths, it is necessary to gain data from approximately 18,000 law enforcement agencies.

While the sheer number of local law enforcement agencies is challenging, BJS has nevertheless instituted a collection plan that employs the help of various State respondents to obtain this information.

Given the level of effort required to establish and maintain these partnerships and the need to work within ever present fiscal constraints, BJS has identified a way to economize. We have examined the payoff from quarterly versus annual reporting and have concluded that annual reporting would produce both more complete data and a more efficient collection.

Most jails and law enforcement agencies report no deaths in custody during a given year, so quarterly reports produce no new data. When deaths do occur, it is unlikely that their full investigation will conclude in any given quarter, thus quarterly reports in these instances simply revisits the same deaths with no conclusion.

BJS is committed to providing the best possible data to Congress and the public when reporting on deaths in custody. As evidence of this commitment, we have continued our DCRA statistical collections beyond the expiration date of the "Death in Custody Reporting Act of 2000."

Last week, BJS launched the "Deaths in Custody" section on our Web site. This section provides a series of detailed tables and downloadable spreadsheets for data users, including several years of data from the State prison, local jail and State juvenile correction facility collections.

In the fall of 2007, BJS plans to issue its first report on arrest-related deaths. Drawing on roughly 2000 records of deaths submitted by over 40 States during a 3-year period, this study will provide a detailed analysis of circumstances surrounding these deaths, including the use of weapons or force against arresting officers, attempts to flee or resist arrest, and the influence of alcohol or drugs at the time of arrest.

The use of various weapons and restraint devices by law enforcement officers will also be studied.

In the future, BJS also plans to release a report analyzing the medical causes related to deaths in local jails, where over half of all inmate deaths are caused by medical problems.

BJS also looks forward to updating our published report on suicide and homicide trends in correctional facilities to look for changing patterns in these violent deaths.

This concludes my statement, Mr. Chairman. Thank you for the opportunity to speak with you today, and I would be pleased to answer any questions you may have.

[The prepared statement of Mr. Sedgwick follows:]

PREPARED STATEMENT OF JEFFREY SEDGEWICK

Department of Justice

STATEMENT OF

JEFFREY SEDGWICK
DIRECTOR
BUREAU OF JUSTICE STASTICS
DEPARTMENT OF JUSTICE

BEFORE THE

SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY
COMMITTEE ON THE JUDICIARY
UNITED STATES HOUSE OF REPRESENTATIVES

CONCERNING

H.R. 2908, THE DEATH IN CUSTODY REPORTING ACT OF 2007

PRESENTED

JULY 24, 2007

WRITTEN TESTIMONY FOR JEFFREY SEDGWICK
DIRECTOR, BUREAU OF JUSTICE STASTICS
DEATH IN CUSTODY REPORTING ACT OF 2007
HOUSE JUDICIARY COMMITTEE
SUBCOMMITTEE ON CRIME, TERRORISM AND HOMELAND SECURITY
JULY 24, 2007

Chairman Scott, Ranking Member Forbes, and distinguished Members of the Committee, I am Jeffrey Sedgwick, Director of the Bureau of Justice Statistics (BJS). BJS is the official statistical agency of the U.S. Department of Justice (DOJ), and a component of the Office of Justice Programs (OJP). As with other statistical agencies across government, our "principal function is the compilation and analysis of data and the dissemination of information for statistical purposes….Statistical purposes relate to descriptions of groups and exclude any interest in or identification of any individual person or economic unit." They do "not do so for administrative, regulatory, or law enforcement purposes.[1]" These distinctions help us to meet our mission of collecting, analyzing, publishing and disseminating information on crime, criminal offenders, victims of crime, and the operation of justice systems at all levels of government. I am pleased to be here today to discuss the Deaths in Custody Reporting Act (DICRA).

The Importance of the Death in Custody Reporting Act

The health and well-being of persons subject to the custody of law enforcement and correctional authorities is an important issue in criminal justice. Collecting and reporting data on deaths in custody is also an important part of the Office of Justice Programs' mission "… to improve the fair administration of justice across America" and of the

[1] National Research Council (2005). Principles and Practices for a Federal Statistical Agency, Third Edition. Committee on National Statistics. Margaret E. Martin, et al, editors.

Bureau of Justice Statistics' mission "to collect, process, analyze and disseminate accurate and timely information on crime and the administration of justice …"

Successes in Collection

The Death in Custody Reporting Act of 2000 tasked BJS with collecting data on deaths that occur in two primary stages of the criminal justice system: first, deaths occurring "in the process of arrest" or during transfer after arrest; and, second, deaths in jails and prisons.

Mr. Chairman, BJS is committed to fulfilling the data collection and reporting provisions of DICRA. I am pleased to report that the Bureau has been successful in initiating the statistical activities. As a result of BJS's comprehensive collection effort, there is 100 percent coverage for State prisons and over 99 percent coverage for local jails and State-operated juvenile systems. Further, BJS developed a data collection covering State and local law enforcement agencies in more than 40 States. Between 2000 and 2005, the latest year for which complete data are available, BJS has collected and processed records on more than 15,000 deaths in State prisons, nearly 6,000 deaths in local jails, and 2,000 deaths in the process of arrest or transfer to detention.

Since the Act was passed, BJS has released two groundbreaking reports on deaths in custody: a special report on suicide and homicide in state prisons and local jails; and a report on medical causes of death in State prisons. These reports offered the first opportunity to analyze the personal characteristics, current offenses, and environmental

factors surrounding inmate deaths on a national scale. While the first report highlighted sharp declines in suicide and homicide rates, it also provided important insights into the characteristics of persons most at risk of death, as well as knowledge of variations in death rates among systems and facilities. The second report concerned medical causes of death in state prisons, giving Congress and the public the first detailed look into the physical health and characteristics of inmates whose death in custody was medically-related (a category that accounts for 89 percent of deaths in state prisons).

In addition, BJS has recently released a comprehensive web-based update, providing detailed information on deaths in jails, prisons, and state operated juvenile facilities. Though it often takes months to finalize information on the cause of death, these web-based updates allow BJS to release data on deaths in custody in the timeliest manner possible.

BJS has also had remarkable success in implementing web-based technologies for collecting data required under DICRA. In 2005, approximately 60 percent of state prison systems and 40 percent of local jail reporters submitted data using a secure web site, resulting in an enormous savings to the data providers as well as to the Federal government.

A further achievement has been BJS' coding of deaths using the World Health Organization's International Statistical Classification of Diseases. While this has been a labor-intensive effort, involving the processing of more than 4,000 death records every

year with up to five different causes per decedent, it has provided BJS and researchers nationwide the unique capacity to compare inmate death rates with rates experienced by U.S. residents in the general population, by cause of death. This is invaluable information for understanding the medical causes of death and, ultimately, for assessing the quality of health care in correctional facilities.

The Ongoing Challenges

Though BJS has had tremendous success thus far in implementing the data collection provisions of DICRA, we face difficulties in obtaining information on deaths that occur "in the process of arrest" or in transit after arrest. To fully measure such deaths, it is necessary to gather data from approximately 18,000 law enforcement agencies. While the sheer number of local law enforcement agencies is challenging, BJS has nevertheless instituted a collection plan that employs the help of various state respondents to obtain this information.

This plan largely relies on State Statistical Analysis Centers (SACs) acting as intermediaries to gather information from law enforcement agencies in their individual states, though other state reporters are also involved, ranging from universities to state attorneys general offices. The result is a collection of law enforcement deaths that currently covers 42 states. BJS plans to continue building partnerships with state respondents to ensure continued cooperation and will continue efforts to obtain participation from states presently not cooperating.

Given the level of effort required to establish and maintain these partnerships, and the need to work within ever-present fiscal constraints, BJS has identified a way to economize. We have examined the payoff from quarterly versus annual reporting and have concluded that annual reporting would produce both more complete data and a more efficient collection. Most jails and law enforcement agencies report no deaths in custody during a given year, so quarterly reports produce no new data. When deaths occur, it is unlikely that their full investigation will conclude in any given quarter; thus quarterly reports in these instances simply revisit the same deaths with no conclusion.

Commitment to Continued Data Collection Efforts

BJS is committed to providing the best possible data to Congress and the public when reporting on deaths in custody. As evidence of this commitment, we have continued our DICRA statistical collections beyond the expiration of the Death in Custody Reporting Act of 2000.

Last week, BJS launched a Deaths in Custody section on our web site. This section provides a series of detailed tables and downloadable spreadsheets for data users, including several years of data from the state prison, local jail and state juvenile correctional facility collections. Detailed descriptions of our data collection methodology are also provided for each collection in this series. Furthermore, BJS is working with the National Archive of Criminal Justice Data at the University of Michigan to provide public-use versions of these data files to external users.

In the fall of 2007, BJS plans to issue its first report on arrest-related deaths. The report will be the first national study of all forms of arrest-related deaths, such as suicides during arrest attempts, accidental injury deaths at arrest scenes and deaths of arrestees held in police stations and short-term booking facilities. Drawing on roughly 2,000 records of deaths submitted by over 40 States during a three-year period, this study will provide a detailed analysis of circumstances surrounding these deaths, including the use of weapons or force against arresting officers, attempts to flee or resist arrest, and influence of alcohol or drugs at the time of arrest. The use of various weapons and restraint devices by law enforcement officers will also be studied.

In the future, BJS also plans to release a report analyzing the medical causes related to deaths in local jails, where over half of all inmate deaths are caused by medical problems. BJS also looks forward to updating our published report on suicide and homicide trends in correctional facilities, to look for changing patterns in these violent deaths.

Mr. Chairman, BJS remains the most respected source for criminal justice statistics in our nation and serves as a centerpiece of the nation's "crime radar," producing the benchmarks and measures necessary for good criminal justice policy. BJS currently employs 58 full-time employees and available funding in FY 2007 for its criminal justice statistics program was approximately $34.5 million. Each year BJS publishes approximately 50 in-depth reports, describes the characteristics of approximately 23 million criminal victimizations, analyzes the operations of the approximately 50,000 agencies, offices, courts, and institutions that comprise the justice system, and maintains

nearly four dozen major data collection series. These efforts allow BJS to accurately identify for the nation the salient characteristics of nearly every stage of the justice process, from victimization to court processes, sentencing to corrections.

This concludes my statement Mr. Chairman. Thank you for the opportunity to speak with you today. I would be pleased to answer any questions you may have.

Mr. SCOTT OF VIRGINIA. Thank you.

Before Mr. Sullivan, let me recognize the gentlelady from California, Ms. Waters, and the gentleman from Ohio, Mr. Chabot, who are with us today, the gentleman from North Carolina, Mr. Coble, and the gentleman from Massachusetts, Mr. Delahunt, who have been here.

Mr. Sullivan?

TESTIMONY OF CHARLES SULLIVAN, EXECUTIVE DIRECTOR AND CO-FOUNDER, INTERNATIONAL CITIZENS UNITED FOR REHABILITATION OF ERRANTS, WASHINGTON, DC

Mr. SULLIVAN. Thank you, Mr. Chairman.

The reporting of deaths in custody is the only true objective statistic that points at the conditions of incarceration. Statistics such as disciplinary infractions or even accreditation presume some subjectivity.

However, each of the almost estimated 5,000 deaths reported this year to the Bureau of Justice Statistics is an objective indicator of how a particular prison or jail is doing in regard to security and medical care.

BJS will also be given the name, gender, race and age of the deceased, as well as the date, time and location of death. Finally, there will be a brief description of the circumstances surrounding the death.

Through these reports, BJS has been able to analyze the personal characteristics, current offense and environmental factors surrounding these deaths. General highlights have shown that suicides in jails have substantially declined since the early 1980's, while homicides in State prisons have dropped an astounding 93 percent.

Besides overall statistics, BJS has also been able to publish the number of deaths in each State, as well as in the 50 largest jail jurisdictions throughout the country.

Since this data about deaths is already collected by BJS, I would suggest that BJS place all these reports, including the names of the deceased, on its Web site. Relatively speaking, this is not a large number of deaths. It would include about 3,000 deaths in State prisons, 1,000 in jails, 500 in law enforcement custody, and about 25 in juvenile correctional facilities.

I would suggest that these reports be included with the State from which they came. Also, the deaths should be listed with the facility and the State where the death occurred. Where no deaths occurred, the facility would not be listed.

When a year is completed, BJS would issue a news release. I suggest this, because in preparation for my testimony, I talked to wardens and national prison and jail experts. No one really was that familiar with these excellent statistics that BJS has collected.

Having details of the deaths on its Web site would communicate the extreme importance of this objective data to the public, especially to corrections professionals. In the same way, the goal of the reporting of deaths in custody is to have all deaths reported.

Presently, deaths in Federal custody are not reported. My second recommendation is to include deaths in the Federal Bureau of Prisons, immigration detention centers, and other Federal jurisdictions.

Including on the BJS Web site all reported deaths, details, all reported details of all deaths in custody throughout the United States, it seems to me, would be the next step toward reducing deaths in custody. By highlighting the details of each death, the corrections and law enforcement professions could examine why this death occurred and how deaths like this can be prevented in the future.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Sullivan follows:]

PREPARED STATEMENT OF CHARLES SULLIVAN

The reporting of deaths in custody is the only true objective statistic that points to the conditions of incarceration. Statistics such as disciplinary infractions or even accreditation presume some subjectivity. However, each of the almost 5,000 deaths reported this year to the Bureau of Justice Statistics is an objective indicator of how a particular prison or jail is doing in regard to security and medical care.

BJS will also be given the name, gender, race, and age of the deceased as well as the date, time and location of the death. Finally, there will be a brief description of the circumstances surrounding the death.

Through these reports, BJS has been able "to analyze the personal characteristics, current offense and environmental factors" surrounding these deaths. General highlights have shown that suicides in jails have substantially declined since the early eighties while homicides in state prisons have dropped an astounding 93%.

Besides overall statistics, BJS has also been able to publish the number of deaths in each state as well as in the 50 largest jail jurisdictions.

Since this data about deaths is already collected by BJS, I would suggest that BJS place all all these Reports, including the names of the deceased, on its web site.

Relatively speaking, this is not a large number of deaths. It would include about 3,000 deaths in state prisons, 1,000 in jails, 500 in law enforcement custody and 25 in juvenile correctional facilities. I would suggest that these reports be included with the state from which they came. Also, the deaths would be listed with the facility in the state where the death occurred. When no deaths occurred, the facility would not be listed.

When a year is completed, BJS would issue a news release. I suggest this because in preparation for my testimony, I talked to wardens, and national prison and jail experts. No one really was that familiar with the excellent statistics BJS has collected. Having details of the deaths on its web site would communicate the extreme importance of this objective data to the public especially to corrections professionals.

In the same way, the goal of the reporting of deaths in custody is to have ALL deaths reported. Presently, deaths in federal custody are not reported. My second recommendation is to include deaths in the Federal Bureau of Prisons, immigration detention centers and other federal jurisdictions.

Including on the BJS web site ALL reported details of ALL deaths in custody throughout the United States would be the next step toward reducing deaths in custody. By highlighting the details of each death, the corrections and law enforcement professions can examine why this death occurred and how deaths like this can be prevented in the future.

Mr. SCOTT OF VIRGINIA. Thank you, Mr. Sullivan.

Ms. Gainsborough?

TESTIMONY OF JENNI GAINSBOROUGH, WASHINGTON OFFICE DIRECTOR, PENAL REFORM INTERNATIONAL, WASHINGTON, DC

Ms. GAINSBOROUGH. Thank you, Mr. Chairman and Members of the Committee. I appreciate the opportunity to speak to you today.

And I also wanted to say how much I appreciate the Chairman for introducing this bill again and for all his work over the years and continuing support for upholding the human and civil rights of incarcerated people. They are much appreciated by all of us working to reform the prison system.

The United States has more people behind bars than any other country in the world, not only in absolute numbers, but as a percentage of its population. We lock up people at a rate 10 to 15 times higher than any other industrialized democracy. Almost one-quarter of the world's total number of prisoners is held in the U.S.

Yet, despite the size of our incarcerated population, we lack any mandated national standards or any systemic oversight to ensure the conditions of confinement adhere to constitutional or human rights standards.

Because it is so difficult to find out what happens in prisons and to ensure that the necessary steps are taken to produce systemic reforms, those instruments that we do have, such as the "Death in Custody Reporting Act," are of great importance.

The Chairman has already talked about the problems that led to the passing of DCRA originally in 2000 and the encouraging results that we have seen at least in some areas of deaths since those times, and it is very clear that we need this reporting to continue.

The measurement of deaths in custody is crude, but it is an important measure for evaluating the culture of an institution. It reflects on health care, suicide prevention, prisoner-on-prisoner violence, and staff-on-prisoner violence. It will become a more effective tool in preventing deaths if the data it produces are used to make improvements in correctional health care, classification systems, suicide prevention, staff assignment and training, even facility design, all areas that could make a significant difference in preventing deaths.

Learning how many people die of different illnesses is important, but it is only a beginning or, rather, it is an end, a snapshot of a final outcome. We need the information about deaths in order to analyze problems, improve faulty systems and work to reduce the numbers as much as possible.

Unfortunately, the tendency is to hide the problems that exist precisely because government does not want to acknowledge or deal with them. It was extremely discouraging to learn from the recent testimony of the last surgeon general that the Bush administration prevented the release of the report on prison health care produced by his office because of fears that it would lead to calls for reform.

The publication of a major report to Congress, the health status of soon to be released inmates, was also delayed for a long time and finally released with as little attention drawn to it as possible.

In 1996, Congress acted to limit the role of the Federal courts in protecting prisoners from abuse by passing the "Prison Litigation Reform Act." These actions are all symptomatic of a lack of concern at all levels of government for the well-being of people who have no alternative but to rely on the State to meet their health-care needs.

They also suggest a lack of concern for the well-being of people who work in prisons, whose own health can be threatened.

Asking for greater oversight and transparency of what happens in prisons and jails is not to undermine the professionalism of prison administrators or to call into question the good intentions of the majority of them. No one doubts that providing good health care in prison is challenging.

People going into prisons and jails are likely to have greater health-care problems than those in the free world. People who become prisoners are generally poor, have not had good health care in their lives, and are often abusers of alcohol and drugs.

But the fact that staff face difficult circumstances of the people in their care is an argument for greater, not less oversight. Adequate treatment of the physical and mental illness of people held in the custody of the State is not just a human right, but has important implications for the health and safety of the communities to which they will, in time, turn and to the health and safety of those who work in prisons and come in daily contact with them.

The increased privatization of health care in prisons has certainly damaged the standard of care in many institutions. Reports and lawsuits have made it clear that a system in which companies submit low bids in order to win contracts and then cut back on services and personnel in order to maximize profits can lead directly to suffering and death.

There are many reports and information about some of these problems. I touch some in my testimony and will be very happy to provide more.

Private prison companies, both those providing health care and those owning prisons and managing the full range of custodial services, present particular problems to the lack of transparency and oversight. And I am very concerned about the wording of the bill that is out now, which does not explicitly include facilities operated by for-profit companies, and I would like to see language really make that clear.

It is particularly problematic because those facilities include many of the immigrant detention centers, where problems have been reported. The Department of Homeland Security's inspector general issued a report earlier this year and found problems with medical care in a number of facilities.

Immigration and Customs Enforcement, ICE, told the New York Times last month that 62 inmates died in its custody from 2004 to 2006. The ACLU has documented many instances of medical neglect leading to death.

The number of people in immigration detention has doubled in a decade to 27,000 or more on any given day and negligent medical care is among the most frequent complaints by detainees nationwide.

As currently written, DCRA does not require these deaths to be reported and this clearly, too, needs to be changed.

Reporting alone will not solve the problems of health care in places of detention nor the other conditions that can lead to the death of prisoners, whether it is through suicide or violence inflicted by others. But understanding why prisoners die is an essential step in improving the system. It is one tool that can help to open up a closed world and provide some transparency.

We see DCRA as one opportunity among several to improve current standards of care for people under the control of the State. The regulations to be developed under the "Prison Rape Elimination Act" will provide another tool and we hope there will be some strengthening of oversight and conditions in juvenile facilities

included the reauthorization of the "Juvenile Justice and Delinquency Prevention Act."

We also remain hopeful that one day the United States will ratify the optional protocol to the convention against torture, which would require us to develop a system of internal oversight and inspection.

I realize that I am over my time and I will stop, but I will be very happy to provide any further information to the panel. Thank you.

[The prepared statement of Ms. Gainsborough follows:]

PREPARED STATEMENT OF JENNI GAINSBOROUGH

My name is Jenni Gainsborough. I am the Director of the Washington Office of Penal Reform International (PRI). PRI is the world's largest international criminal justice reform organization working to improve access to justice, reduce the overuse of incarceration and ensure the humane treatment of prisoners in accordance with human rights laws, standards and norms. The Washington office's particular mandate is to broaden the knowledge and understanding of human rights mechanisms and standards in the U.S. among criminal justice reformers, policy makers and administrators and to encourage their integration into policy and practice here.

Thank you for the invitation to address the Subcommittee on the issue of reporting deaths in custody. I would also like to thank Representative Scott for introducing HR 2908, the Death in Custody Reporting Act. His leadership on this issue as well as his continuing support for upholding the human and civil rights of incarcerated people are greatly appreciated by all of us working to reform the prison system.

The United States now has more people behind bars than any other country in the world, not only in absolute numbers but as a percentage of its population. Our incarceration rate of more than 737 per 100,000 is ten to fifteen times the rate of other industrialized democracies. We lock up more people, including children, for longer periods of time and the numbers and percentages increase every year. Almost one quarter of the world's total number of prisoners is held in the U.S. Yet despite the size of our incarcerated population, we lack any mandated national standards or any system for systemic oversight to ensure that conditions of confinement adhere to constitutional or human rights standards.

Because it is so difficult to find out what happens in prisons and to ensure that the necessary steps are taken to produce systemic reforms, those instruments that we do have, such as the Death in Custody Reporting Act (DICRA) are of great importance. DICRA was passed originally in 2000 as a result of concerns about the questionable circumstances in thousands of deaths in police and prison custody. Before DICRA, data collection on prison deaths was incomplete in part because states lacked the incentive to participate but also because states were inconsistent in their reporting methods and the Bureau of Justice Statistics only required prisons to report aggregate death statistics rather than the details of individual cases.

The measurement of deaths in custody is a crude but important measure for evaluating the culture of an institution—it reflects on healthcare, suicide prevention, prisoner-on-prisoner violence, and staff on prisoner violence. It will become a more effective tool in preventing deaths if the data it produces are used to make improvements in correctional healthcare, classification, suicide prevention, staff assignment and training, facility design, and other areas that can make a significant difference in preventing deaths.

Learning how many people die of different illnesses is important but it is only a beginning—or rather it is an end, a snapshot of a final outcome. We need the information about deaths in order to analyze problems, improve faulty systems and to work to reduce the numbers as much as possible. Unfortunately, the tendency is to hide the problems that exist precisely because government does not want to acknowledge or deal with them.

It was extremely discouraging to learn from the recent testimony of the last Surgeon General that the Bush administration prevented the release of the report on prison health care produced by his office because of fears that it would lead to calls for reform. The publication of a major report to Congress, The Health Status of Soon-to-be-Released Inmates was also delayed for a long time and was finally released in May 2002 so as to draw as little attention as possible. In 1996, despite the fact that changing case law was already making it more difficult to obtain remedies in prisoner abuse cases, Congress acted to limit the role of the federal courts

in protecting prisoners from abuses by passing the Prison Litigation Reform Act (PLRA). The limitations on the role of the courts imposed by the PLRA, further reduced oversight of what happens in the closed world of prisons.

These actions are symptomatic of a lack of concern at all levels of government for the well being of people who have no alternative but to rely on the state to meet their healthcare needs. They also suggest a lack of concern for the well being of people who work in prisons whose own health can be threatened.

Asking for greater oversight and transparency of what happens in prisons and jails, is not to undermine the professionalism of prison administrators or to call into question the good intentions of the majority of them. No one doubts that providing good healthcare in prison is challenging. People going into prisons and jails are likely to have greater health problems than those in the free world. People who become prisoners are generally poor and have not had good healthcare in their lives. They are often abusers of alcohol and drugs. A high percentage suffer from mental illnesses, often severe and often untreated. But the fact that staff face difficult circumstances with the people in their care is an argument for greater, not lesser, oversight. Adequate treatment of the physical and mental illnesses of people held in the custody of the state is not just a human right but it has important implications for the health and safety of the communities to which they will in time return and to the health and safety of those who work in prisons and come into daily contact with them. Communicable diseases like tuberculosis, Hepatitis C and HIV reach the public through people released from prison and those who visit or work inside places of detention.

The increased privatization of healthcare in prisons has certainly damaged the standard of care in many institutions. Reports and laws suits have made it clear that a system in which companies submit low bids in order to win contracts and then cut back on services and personnel in order to maximize profits can lead directly to suffering and death. Prison Health Services (PHS), one of the largest private prison healthcare companies, has lost contracts in a number of jurisdictions, for example in Hillsborough County, FL, where a pregnant woman complained of labor pains for 12 hours before giving birth over a toilet to a baby who died on the way to the hospital; Dutchess County, N.Y., where a 35-year-old woman died after PHS doctors ignored her claims of chest pain for 10 days; Schenectady County, N.Y., where a Parkinson's patient was deprived of most of his medication and left to die in a bed soaked in his own urine.

Private prison companies, both those providing healthcare and those owning prisons and managing the full range of custody services, present particular problems of lack of transparency and oversight. They often try to hide their problems by making claims of proprietary business information and, when lawsuits are brought, often settle out of court and impose requirements of confidentiality about the details of such settlements. I am concerned about the wording of HR 2908 which refers to the need to report "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)." Unfortunately, this language does not explicitly include facilities operated by for-profit companies. Those facilities include many of the immigrant detention centers where problems have been reported.

The Department of Homeland Security's inspector general issued a report earlier this year and found problems with medical care in a number of facilities. Immigration and Customs Enforcement (ICE) told the New York Times last month that 62 inmates died in its custody from 2004 to 2006. The American Civil Liberties Union (ACLU) has documented many instances of medical neglect leading to death. Among those who died while in ICE custody were a man from Sierra Leone who collapsed at a Virginia jail after saying he did not get medicine for a kidney ailment, a woman from Barbados who died in another Virginia jail after telling her sister that she received no medicine for a uterine fibroid that caused hemorrhaging, and a South Korean woman who died after cellmates appealed to authorities for help over a period of weeks. The number of people in immigration detention has doubled in a decade to 27,500 on any given day. Meanwhile, negligent medical care is among the most frequent complaints by detainees nationwide. As currently written, DICRA does not require these deaths to be reported. This clearly needs to be changed.

Reporting alone will not solve the problems of healthcare in places of detention, nor the other conditions that can lead to the death of prisoners whether through suicide or violence inflicted by others, but understanding why prisoners die is an essential step in improving the system. It is one tool that can help to open up a closed world and provide some transparency. DICRA requires the Attorney General to develop guidelines for the reporting of data and we hope that the Attorney General will use that opportunity to ensure that the information is collected and dis-

seminated in a way that maximizes its usefulness. It would be extremely helpful if the process began with discussions between all the stake holders to devise the best possible system to make sure that happens.

We see DICRA as one opportunity among several to improve current standards of care for people under the control of the state. The regulations to be developed under the Prison Rape Elimination Act will provide another tool for greater transparency and we hope that there will be some strengthening of oversight of conditions in juvenile facilities included in the reauthorization of the Juvenile Justice and Delinquency Prevention Act. We also remain hopeful that one day the United States will ratify the Optional Protocol to the Convention Against Torture (OPCAT). The OPCAT would require us to develop a system of internal oversight and inspection appropriate to our federal system while ensuring that no one deprived of liberty is also deprived of a mechanism to ensure basic standards of humane treatment regardless of where he or she is held.

It is simply inconsistent with the values and principles of the United States to continue to lock up so many people without providing the minimum levels of oversight that are considered essential in other western democracies. We very much appreciate the opportunity to draw attention to the need for the Deaths in Custody Reporting Act. Obviously, this testimony can only provide a very brief overview of some of the concerns that we would like to see addressed. There are problems at all stages of the system—people dying after the use of tasers and electronic stun guns by the police, children dying in boot camps and detention facilities because of abusive treatment, and problems with inadequate healthcare in prisons and jails. I would be more than happy to provide further information on any of the points raised here.

Once again, I would like to thank the Subcommittee and Representative Scott for raising these issues and for working to ensure the continuation of the reporting requirements of DICRA.

Mr. SCOTT OF VIRGINIA. Thank you very much, Ms. Gainsborough.

Ms. Scott?

TESTIMONY OF MARY SCOTT, MOTHER OF JONATHAN MAGBIE, MITCHELLVILLE, MD

Ms. SCOTT. Good afternoon. My name is Mary Scott. And I first want to thank you for this opportunity to give this testimony on behalf of my son, Jonathan.

Mr. COBLE. Mr. Chairman, could you ask Ms. Scott to maybe pull the mike a little closer?

Ms. SCOTT. Again, my name is Mary Scott, and I first want to thank you for this opportunity to give this testimony on behalf of my son, Jonathan Magbie, and also others who have died while in the prison or jail.

I offer this statement as support of the reauthorization of the "Death in Custody Reporting Act."

My son Jonathan's death represents the height of the corrections system's and perhaps the criminal justice system's brutality and inhumanity. You see, at the time of his death, Jonathan was a 27-year-old quadriplegic, literally without the ability to control any of his body functions, even breathing.

On September 20, 2004, Jonathan was given a 10-day sentence by a D.C. superior court judge for a first-time marijuana possession. He didn't deny that he smoked. In fact, he told the judge that it made him feel better. Little did he know that this statement would cost him his life.

Let me briefly explain.

Jonathan was a respiratory-dependent quadriplegic. As a result of being hit by a car at the age of 4, he was paralyzed from the neck down and needed a ventilator to breath.

His 10-day sentence to the District of Columbia jail became a grueling and inexplicable ordeal. While in the prison, he was deprived of basic medical services, isolated in a closed-door cell, from where he had absolutely no capability of communicating, left dehydrated and medically misdiagnosed.

The D.C. jail and its medical staff, with the court's sanction, accepted Jonathan into custody and then abandoned him. Five days later, he was dead.

How was his death reported to the Department of Justice? To what extent were the actual facts and circumstances and especially the causes of his death documented and examined? How was it that a man who was able to survive a debilitating accident at age 4, experienced life-threatening bouts with pneumonia, a life-threatening bone infection and numerous surgeries, was unable to survive 5 days in jail?

The Department of Justice should know that this quadriplegic was not properly suctioned, that if his lungs weren't properly cleared, that he was not properly catheterized, that he was not properly fed nor given necessary fluids, that he lost more than 20 pounds in 5 days, that he was locked in a closed room and deprived of proper medical attention.

What happened to my son epitomizes the potential cruel and inhuman treatment that an isolated and vulnerable inmate can experience.

The point here is that Jonathan's death and the particular circumstances surrounding his death should be documented in the interest of public accountability. This information should be examined, in my opinion, to ensure that others learn from the mistakes of this experience and not repeat them hopefully ever again.

As a mother of a son who died a traumatic death while in custody, I strongly urge this Committee to support reauthorization of the "Death in Custody Reporting Act." Our government and our society need a law which requires uniform reporting of prison deaths to the Department of Justice.

Such a law should also state specific consequences for noncompliance. No justice system, especially ours, should transcend public accountability or the letter of the law.

Therefore, the government and the public should know when and how people die in custody. Judicial determinations that someone should be incarcerated should not mean that those individuals' humanity or the humanity of that very system of incarceration is nullified.

I am not necessarily pointing a finger and casting universal blame for jail and prison-related deaths. What I am saying is that these deaths, for whatever reason, command public attention and especially the attention of government leaders and decision-makers who seek to make that system and more responsible.

I am not a lawyer, but I do know that the common thread of government interest related to these deaths is the question whether our corrections system is meeting Federal standards and constitutional protections.

In Jonathan's case, it is significant that the D.C. government conducted an investigation and held oversight hearings and sought explanations for Jonathan's death. There is no doubt that knowl-

edge and information are powerful tools in monitoring our corrections system.

The improvement of Federal policies and procedures can only come from vigilant Justice Department and Congressional scrutiny of the knowledge and information such as that required in this law.

I sincerely thank you for the opportunity to appear before you today, and I trust that your efforts in reauthorizing the law will be successful.

Thank you.

[The prepared statement of Ms. Scott follows:]

PREPARED STATEMENT OF MARY SCOTT

Good afternoon:

My name is Mary Scott, and I first want to thank you for this opportunity to give this testimony, on behalf of my son, Jonathan Magbie, and also others who have died while in the prison or jail. I offer this statement in support of the reauthorization of the Death in Custody Reporting Act.

My son, Jonathan's death represents the height of the correction system's, and perhaps the criminal justice system's, brutality and inhumanity. You see, at the time of his death Jonathan was a 27 year old quadraplegic, literally without the ability to control any of his body functions, even breathing.

On September 20, 2004, Jonathan was given a ten (10) day sentence by a D.C. Superior Court judge for a first time offense of marijuana possession. He didn't deny that he smoked. In fact, he told the judge that it made him feel better. Little did he know that this statement would cost him his life.

Let me briefly explain. Jonathan was a respiratory dependent quadriplegic. As a result of being hit by a car at age four, he was paralyzed from the neck down and needed a ventilator to breathe. His ten day sentence to the District of Columbia jail became a grueling and inexplicable ordeal. While in the jail, he was deprived of basic medical services, isolated in a closed door cell (from where he had absolutely no capability of communicating), left dehydrated and medically misdiagnosed. The D.C. jail and its medical staff, with the court's sanction, accepted Jonathan into custody, and then abandoned him. Five days later, he was dead.

How was his death reported to the Department of Justice? To what extent were the actual facts and circumstances, and especially the causes of his death, documented and examined? How was it that a man who was able to survive a debilitating accident at age four, experience life threatening bouts with pneumonia, a life threatening bone infection and numerous surgeries, was unable to survive five (5) days in jail? The Department of Justice should know that this quadriplegic was not properly suctioned, that his lungs were not properly cleared, that he was not properly catheterized, that he was not properly fed nor given necessary fluids, that he loss more than twenty pounds in five days, that he was locked in a closed room, and deprived of proper medical attention.

What happened to my son epitomizes the potential cruel and inhuman treatment that an isolated and vulnerable inmate can experience.

The point here is that Jonathan's death, and the particular circumstances surrounding his death, should be documented in the interest of public accountability. This information should be examined, in my opinion, to ensure that others learn from the mistakes of this experience and not repeat them, hopefully ever again.

As a mother of a son who died a traumatic death while in custody, I strongly urge this Committee to support reauthorization of the Death in Custody Reporting Act. Our government and our society need a law which requires uniform reporting of prison deaths to the Department of Justice. Such a law should also state specific consequences for noncompliance.

No justice system, especially ours, should transcend public accountability or the letter of the law. Therefore, the government and the public should know when and how people die in its custody. Judicial determinations that someone should be incarcerated should not mean that that those individuals' humanity or the humanity of that very system of incarceration is nullified. I am not necessarily pointing a finger and casting universal blame for jail and prison related deaths. What I am saying is that these deaths, for whatever reason, command public attention and especially the attention of government leaders and decision makers who seek to make that system safer and more responsible.

I am not a lawyer, but I do know that the common thread of government interest related to these deaths is the question whether our corrections system is meeting federal standards and constitutional protections.

In Jonathan's case, it is significant that the D.C. government conducted an investigation and held oversight hearings, and sought explanations for Jonathan's death. There is no doubt that knowledge and information are powerful tools in monitoring our corrections system. The improvement of federal policies and procedures can only come from vigilant Justice Department and congressional scrutiny of the knowledge and information such as that required in this law.

I sincerely thank you for the opportunity to appear before you today and I trust that your efforts in reauthorizing the law will be successful. THANK YOU.

Mr. SCOTT OF VIRGINIA. Thank you, Ms. Scott.

Ms. Scott, are you represented by a lawyer? Could you identify him, in case there are questions, technical questions you may be asked?

Ms. SCOTT. Mr. Donald Temple and Mr. Cockner.

Mr. SCOTT OF VIRGINIA. In case there are questions, Mr. Temple is here.

Without objection, the Subcommittee will be recessed shortly, subject to the call of the Chair, so the Subcommittee can proceed with a previously scheduled markup.

[Recess.]

Mr. SCOTT OF VIRGINIA. The Chair now recesses the Subcommittee markup and resumes the Committee hearing on the bill.

And I recognize myself for 5 minutes for questions.

Mr. Sedgwick, you mentioned the problem of defining the process of arrest. Could you recommend how we could clarify that so there would not be any question?

Mr. SEDGWICK. The problem is not in defining the process of arrest. The difficulty is in collecting data from that particular stage of custody or that particular form of custody.

The challenge that we face with the law enforcement community, quite frankly, is that there are 18,000 law enforcement units in the United States. Only two States have mandatory or required reporting by local law enforcement to a State agency of deaths in custody.

The consequences in terms of trying to collect accurate data on deaths that occur in the process of arrest or transport subsequent to arrest is, essentially, it requires us to go out and establish some type of data collection mechanism with 18,000 different agencies, which has proven to be probably the most time-consuming task that we have been involved in with DCRA and it is part of the reason why we will be getting around to doing our first report on deaths in the process of law enforcement or arrest-related deaths this fall. It has simply taken a very long time.

How we solve that problem is a question on which the Department has not taken a position. I can say from the point of view of BJS, as a data collection agency, it is an awful lot easier for us to get information out of those two States that have mandatory State laws requiring deaths in local law enforcement agencies be reported to the State government.

It is much easier for us to collect data in those States than it is in the other 48.

Mr. SCOTT OF VIRGINIA. Thank you.

The question has been raised about whether or not the reporting is required for, I guess, contracted incarceration under the for-prof-

it facilities. Is there any question about whether or not they are included under the present language?

Mr. SEDGWICK. Right now, we collect data for State prisons from State departments of corrections. So if a State department of corrections has operating under its jurisdiction a contract-out service, yes, we would get data from those institutions.

Mr. SCOTT OF VIRGINIA. There appeared to be some question about that. So you wouldn't have a problem with us making that clear that they are——

Mr. SEDGWICK. Not at all.

Mr. SCOTT OF VIRGINIA [continuing]. To be included.

Mr. SEDGWICK. Not at all.

Mr. SCOTT OF VIRGINIA. Do you include a difference in juvenile facilities and juveniles in adult facilities?

Mr. SEDGWICK. We do not, under the juvenile collection, include juveniles that are held in adult facilities, because they are reported by the adult facility. So to avoid double counting, any juvenile that is held in an adult facility in the United States is reported under the adult prison collection, not under the separate juvenile collection.

Mr. SCOTT OF VIRGINIA. But you would have the juveniles' age in that reporting.

Mr. SEDGWICK. We would.

Mr. SCOTT OF VIRGINIA. Do you know what the Department of Justice does with the numbers or, particularly, what they do when they notice a high number of deaths coming from a particular facility?

Mr. SEDGWICK. I do not, not as the Director of a statistical agency. I am not privy to those kinds of operational decisions.

Mr. SCOTT OF VIRGINIA. Thank you.

Mr. Sullivan, in publicizing the information, are there any concerns that you might see in terms of violation of persons' privacy?

Mr. SULLIVAN. Mr. Chairman, I talked to an attorney about this and it doesn't seem to be any problem with actually including the name of the individual.

There was a Supreme Court decision a few years ago concerning the suicide events, Foster, where someone was investigating that and wanted pictures in regard to the suicide, et cetera, and the Supreme Court said, "No, you cannot receive these pictures."

But there was no problem with the name and this particular attorney, who I can certainly provide his name to the Subcommittee, seems to be very aware that there would not be any privacy problems in including the deceased.

Mr. SCOTT OF VIRGINIA. Thank you.

And, Mr. Sedgwick, you indicated that half of the deaths are caused by medical problems. Exactly what do you mean by that?

Mr. SEDGWICK. No, actually, I think the correct figure is about 89 percent of the deaths that occur in prison are health-related. Among health-related, half of those deaths are caused by cancer or heart disease, I believe.

Mr. SCOTT OF VIRGINIA. So medical problems, you mean disease. You are not talking about malpractice.

Mr. SEDGWICK. Correct.

Mr. SCOTT OF VIRGINIA. I think I will shock my colleague by yielding back at this time to make sure I don't go over.

Mr. FORBES. Thank you, Mr. Chairman.

And thank all the witnesses for being here.

Ms. Scott, we want to thank you for taking time and joining us. I was just wondering if you could describe for us the extent of the medical care that your son required as a result of his condition.

Ms. SCOTT. Jonathan required 24-hour medical or nursing care. He couldn't do anything on his own. He couldn't feed himself or he couldn't breath on his own. So that alone required that he have someone with him at all times.

Mr. FORBES. And was that care provided at home by you or a nurse before he was incarcerated?

Ms. SCOTT. Well, he had 20 hours a day of nursing care. The other 4 hours, the family took responsibility for.

Mr. FORBES. After his death, what explanations were you offered for your son's lack of medical care while he was in jail?

Ms. SCOTT. The lack of care? They never gave me—I mean, they never told me he did not receive the care.

Mr. FORBES. So you were never informed that he wasn't.

Were you able to be involved in any of the investigations of the oversight hearings that were conducted regarding——

Ms. SCOTT. No.

Mr. FORBES [continuing]. Jonathan's death? So you were excluded basically from all of those.

Has there been any follow-up with you by the D.C. government or the Department of Justice regarding Jonathan's death?

Ms. SCOTT. Follow-up in what way?

Mr. FORBES. About any explanations about why he wasn't given medical care or the situation that led up to his death.

Ms. SCOTT. Donald, is that—we are currently in litigation.

Mr. FORBES. Don't answer anything that you don't feel comfortable doing.

Mr. TEMPLE. My name is Donald Temple. Just briefly, we have worked with the District of Columbia government in their oversight process. There was an inspector general report. There were city council hearings and health department investigation.

As far as the city government is concerned, we did work with them to ascertain the causes of the death and areas in which improvements could be made.

Mr. FORBES. Thank you.

And, Ms. Scott, we are certainly sorry for your loss. Thank you for being here today.

Ms. SCOTT. Thank you.

Mr. FORBES. Mr. Sedgwick, first of all, let me compliment you on a great choice in getting your Ph.D. from the University of Virginia.

And then, also, what are the most common types of illnesses that are attributed to deaths in custody? And in follow-up, are you seeing any changing trends in the type or rate of certain illnesses? And they tend to vary region by region across the country and by type of custody.

Mr. SEDGWICK. On the latter question, I would prefer to give you a written answer to that, because that is pretty detailed.

But we are seeing, I think, as you alluded to, heart disease and cancer accounts for half of all of the illness-related deaths of inmates in prison and, again, I would put that in the context that 89 percent of all State prisoner deaths are medical problems.

We are seeing an increase in the types of illnesses that one would associate with increasing age, which is, in part, a reflection of longer sentences being handed out and, therefore, an aging prison population in the United States.

So causes of death that you would normally associate with aging processes, whether that be lung cancer, heart disease and so on, are tending to become more prevalent.

So I think I would stop there.

Mr. FORBES. And you don't mind submitting, whenever you get the opportunity, for the record——

Mr. SEDGWICK. Not at all.

Mr. FORBES [continuing]. The change by region.

Mr. SEDGWICK. Sure.

Mr. FORBES. Mr. Sullivan, we have a Department of Justice report that indicates that the State prison homicide rate is down 93 percent since the 1980's and that suicide rates are 64 percent lower than in the early 1980's.

Do you have any explanation as to why that might be the case or what would you attribute the dramatic decrease in prisoner suicides and homicides to?

Mr. SULLIVAN. Certainly, I think litigation, as we just discussed, but, also, there has been a move toward professionalism. As Mr. Scott said earlier, I think this reporting has had its impact on this and I don't think corrections is really threatened like they used to be.

It used to be more them and us and whatever, but I think we are all working together to reduce the incidence of death, and that is why I think, to get back to my suggestion, that it be placed on the Internet so that everybody can see.

I think, for example, Ms. Scott does not know for sure whether her son actually—his report was given. I don't think we can verify that, unless it is on the Internet.

So that is why I think we are at a point that maybe we—by having the details, having the studies is so very important, but having the details of each death on the Internet.

We do know that most entities that do report end up filling out a form that is on the Internet. It would be very simple to just forward that to the BJS Web site and have them list it according to their States, so that everybody would know, first of all, that it would be verified that it actually happened, that it was reported, and, secondly, it would be a continual move toward professionalism, where corrections professionals and law enforcement professionals could look at this particular case, this particular reporting of a death in custody and see then is there anything we can learn from this, as we have learned so much in regard to Ms. Scott's son.

Mr. FORBES. Thank you.

My time is up. I yield back the balance.

Mr. SCOTT OF VIRGINIA. Thank you.

The gentlelady from California?

Ms. WATERS. Thank you very much, Mr. Chairman.

I receive many letters from prisoners, some State, some Federal. Many of the complaints have to do with the inability of the inmate to negotiate their medical care inside the institutions.

The complaints include those who go in who are taking medication that cannot get their medication once they have been incarcerated. The complaints include inability to see a doctor and the fact that oftentimes their complaints are just plain ignored inside the prison.

I have written letters on behalf of families trying to get the authorities to respond to the request of the family and/or the inmate, and I am wondering what happens to my letters and letters of other family members.

Are those letters held in a file or recorded in some way so that if, in fact, there is litigation, those lawyers would have access to that information that there have been requests, there had been an attempt to bring to the attention of the authorities that there may be some negligence?

I would like to ask Mr. Sedgwick if he can respond to that.

Mr. SEDGWICK. Such letters are not filed at BJS. I can look into that and get back you and let you know whether or not there is another unit within the Department of Justice that would maintain access or maintain those letters and provide them on request to other parties.

But the data that we collect would not include those letters, no. We send out a standard reporting form that we ask each jurisdiction to fill out, including details on particular circumstances of death. But they would not return with that form letters such as you are describing.

Ms. WATERS. Well, I bring this question up because I suspect that it is very difficult to access those letters in any of the institutions. I suspect that it is true. I don't know it to be true.

However, Mr. Chairman, I bring it up for discussion, because I think it should be considered in the legislation that letters relative to the requests that are being made for medical attention, et cetera, be filed in a way that families and lawyers would have access to that information. I think that would be very important.

Let me just say to Ms. Scott, I am very, very sorry to hear about what happened to your son. I know that you must feel extremely helpless in a case where your son, who had the disabilities that you described and cannot help himself, and, obviously, something went wrong, very, very wrong there.

And so I am hopeful that in addition to your ability to seek some kind of justice for his death, that what we do here in Congress will help to be of assistance to inmates and families for the future. And thank you for coming to testify today.

I yield back the balance of my time.

Mr. SCOTT OF VIRGINIA. Thank you.

The gentleman from North Carolina?

Mr. COBLE. Thank you, Mr. Chairman.

Ms. Scott, when I asked you to pull the mike closer to you earlier, I wasn't being critical of your delivery. It was my hearing impairment which was the problem. [Laughter.]

Ms. Scott, were you involved in any way with the D.C. government investigation or the oversight hearings that were conducted regarding your son's death?

Ms. SCOTT. No, I was not.

Mr. COBLE. Mr. Sedgwick, the two States you mentioned, what are those two States?

Mr. SEDGWICK. California and Texas.

Mr. COBLE. And what are the requirements?

Mr. SEDGWICK. California and Texas have State laws requiring local law enforcement agencies to report all deaths in the process of arrest to be reported to a State agency.

Mr. COBLE. You may have already touched on this. What are the most common types of illnesses that are attributed to deaths in custody?

Mr. SEDGWICK. Medical causes of deaths are overwhelmingly the greatest cause of death for persons in custody in the United States and heart disease and——

Mr. COBLE. What was number one?

Mr. SEDGWICK. Heart disease is 27 percent, and cancer is 23 percent. So 50 percent of 89 percent pass away from those two causes.

Mr. COBLE. Mr. Sullivan, I am told that there has been at least a reporting of the dramatic decrease in prisoner suicides and homicides. To what do you attribute that?

Mr. SULLIVAN. Congressman, I really think there has been a move toward professionalism that we are seeing and reducing these deaths. I think it is something that corrections has, as a profession, has—and because it has come into its own, I think that, in my experience in dealing with correctional professionals, I see much more working together than we have ever worked in the past.

Also, of course, there has been litigation and the reporting of deaths, accountability.

Mr. COBLE. That is encouraging.

Mr. Sedgwick, regarding race, African-American, Caucasian, Hispanic, is there any sort of breakdown ratio-wise there to the number of deaths in custody?

Mr. SEDGWICK. I can provide that information for you in some detail. If you don't mind, I would prefer to give you the response to that in writing, just so I make sure that it is accurate.

Mr. COBLE. That would be fine.

Thank you all for being with us.

Thank you, Mr. Chairman.

Mr. SCOTT OF VIRGINIA. Thank you.

We have a few other questions, if you would.

I recognize myself for 5 minutes.

Mr. Sullivan, is there evidence of underreporting?

Mr. SULLIVAN. No, I don't think so. I think we have 100 percent of the State prison system, but 99 percent of the jails, but I get back to I don't think this program has the respect that it should have.

And I get back to what I keep bringing up, that if the details of each report was on the Web site, I think people could verify that it actually did happen. And I go back to, if I could just elaborate, I think the name of the person deceased should be on the Web site and I use the example of Los Angeles County jail.

I think statistics would show that at least 200 to 300 deaths occur there at that facility every year. People have talked about maybe taking the names and just having the details without the names.

Well, I don't think you would be able to pinpoint exactly who this particular individual is without that name being attached. Now, certainly, in smaller jails, et cetera, where death is a rare event, you would be able to know. But in your large urban jails, you have many more deaths and that is why I feel that the entire report should be transferred to the BJS Web site.

Mr. SCOTT OF VIRGINIA. Thank you.

Mr. Sedgwick, what do you do to audit the numbers to make sure you are getting as accurate a report across the Nation as possible?

Mr. SEDGWICK. In designing a survey or a data collection instrument such as we use for DCRA, we spend a lot of time and pay a lot of attention to the design of the request for information, the form that has to be filled out and so on. We then issue that request for information. We get the responses back.

In terms of a specific audit for us to be able to go in and read the records ourselves, we don't have that type of capability or capacity to do it.

Mr. SCOTT OF VIRGINIA. As Mr. Sullivan has suggested, if you have a name of someone you know through media reports or otherwise that has died in custody, do you check to see if their name would have been reported if you don't do things like that?

Mr. SEDGWICK. We could do that on a case-by-case basis.

Mr. SCOTT OF VIRGINIA. On a random basis, just to see if you are getting accurate numbers.

Mr. SEDGWICK. It could be done. We do not routinely do that now.

Mr. SCOTT OF VIRGINIA. In the reporting, is there evidence that some facilities have a lot more deaths or proportionately a lot more deaths than others?

Mr. SEDGWICK. There are variations across facilities.

Mr. SCOTT OF VIRGINIA. Exactly what is made available to the public?

Mr. SEDGWICK. First of all, we have the public reports that are issued. I have mentioned two that have already been released and another that is due in October, and those are distributed quite widely and accompanied by press releases.

In addition, public access to data tapes and, also, data tapes that are available for research use are made available through the archives at the University of Michigan.

That process, I have to tell you, lags behind the dissemination of the paper reports.

Mr. SCOTT OF VIRGINIA. So if a researcher wanted to do some research, they could get to the original data.

Mr. SEDGWICK. They can get to a restricted use data tape that contains all of the information that we have, but to get that, they first have to go through an institutional review board process and then sign a——

Mr. SCOTT OF VIRGINIA. Confidentiality?

Mr. SEDGWICK [continuing]. Confidentiality statement, as well as a statement that their access to this data tape is for research purposes only.

Mr. SCOTT OF VIRGINIA. So for legitimate research purposes, they can get to the——

Mr. SEDGWICK. We are in the process of making those tapes available as I speak. Public access data tapes are different.

Mr. SCOTT OF VIRGINIA. Ms. Gainsborough, do you have any evidence that many of the deaths are preventable?

Ms. GAINSBOROUGH. It is very hard to get that kind of evidence absent the sort of investigation that would be required on an individual basis. But certainly we do know the results from litigation, for example, where it has been quite clearly established that there has been deficient medical care.

As Congresswoman Waters already spoke about, in California, in particular, there have been endlessly documented examples of really poor health care in the prison system there, which is finally beginning to receive the kind of attention that it needs.

But it is always tough. Prisons are very closed institutions and it is extremely difficult, particularly when the information coming out from prisons is fed through the prison administration, who clearly may have a different agenda to the family of the prisoner, who is often kept in the dark about what went on.

Mr. SCOTT OF VIRGINIA. Thank you.

My time has expired.

The gentleman from Virginia?

Mr. FORBES. Thank you, Mr. Chairman.

And, once again, thank all of you.

When we are up here, one of the things—I support the reporting act, but one of the things we always like to do is take apples and oranges and separate them and make sure we have the facts.

And one of the things—this reporting act came out in 2000, I believe, is that true, Mr. Sedgwick? But we have had this decline in homicides and murders since the 1980's.

And, Mr. Sedgwick, at some point in time, if you could give us a charting of how that fell, because we can't say that all this came because of this reporting act, because some of the statistics I was looking at, the 93 percent drop in suicide rates in jails, I mean, that was from 1983 to 2002 and this would be a truly miraculous act if it just was 2 years and it had all of a sudden reached that 93 percent.

The other thing, just to make sure we are getting a full disclosure of what we have here, while we have this egregious situations, like Ms. Scott went through, and we all want to stop those, Mr. Sedgwick, isn't it also true that most States had no prisoner homicides during the course of a year?

The second thing is, it is true that from 2001 until 2002, 43 percent of all the prison murders took place in just three States—California, Texas and Maryland—according to a BJS report.

The other thing that is interesting to note is this, that during 2002, for example, while we are talking about the homicide rates in our prisons, the homicide rate in the general population was greater than it was in the prisons and the jails. So you actually

had a lower homicide rate in prisons and jails than you had in the U.S. population over a whole. Is that correct for 2002?

And the mortality rate in State prisons from 2001 to 2004 was 20 percent lower in State jails than it was for all of us who weren't in the jails. So while we recognize some of these statistics, we do have to kind of put a face on them.

And one last thing. From 2000 to 2002, White inmates were six times more likely to commit suicide in a jail than African-American inmates and three times more likely than Hispanic inmates.

So when we are looking at this, reporting is important, the statistics are important, but we also have to recognize that a lot of these homicides and murders concentrated in a few States. Overall, the system seems to be doing a fair job, just based on some of the reporting, and at least that the mortality and homicide rates that we are seeing, sometimes they are better inside the jails than they are outside for the general population.

Am I distorting that all, Mr. Sedgwick, or is that a fair——

Mr. SEDGWICK. No. I think you summarized that very accurately.

Mr. FORBES. Good, good. And if you could just help us with that charting. I don't want to overload you with stuff, but that would just help us to take a look and make sure we are doing the right things on the reporting.

But, again, thank you all for being here.

Mr. Chairman, I yield back.

Mr. SCOTT OF VIRGINIA. Does the gentlelady from California have any additional questions?

Ms. WATERS. If I may, just for a minute.

Mr. SCOTT OF VIRGINIA. The gentlelady is recognized for 5 minutes.

Ms. WATERS. Thank you.

I would like to get back to my concerns about the requests for medical attention that are ignored or the family's request for someone to investigate the complaints of their relatives.

And the reason that I want to do this is because some of these inmates die. And I want to know, I would like to know—have information about the lawsuits or the number of accusations against the facility that is alleged by families about the death of their relatives while they are incarcerated.

Do you have that information?

Mr. SEDGWICK. No, I don't. That is not part of the information that we collect under DCRA.

Ms. WATERS. That is not included. Do the various facilities have that information?

Mr. SEDGWICK. I couldn't speculate on that. I would assume that—well, I won't assume. I won't speculate on State institutions that I don't know anything about.

Ms. WATERS. Has this ever been a discussion that you have had with anybody about the accusations of negligence inside the prisons as it relates to requests for medical assistance?

Mr. SEDGWICK. It has not been part of the discussions that we have had about implementing the provisions of DCRA. We do, under the provisions of DCRA, collect information on medical care that was made available to inmates who we then collect information on because they subsequently die.

So we are able to and we have summarized in the reports that we have put out and, most recently, the one on medical causes of death of jail and prison inmates, we were able to give information or summarize information of what percentage of inmates who subsequently died were offered medical care and what sorts of care.

So we were able to gather that kind of information. But the type of information that you are talking about is not information that we have collected under the provisions of DCRA nor am I sure how we would go about trying to get that information.

Ms. WATERS. So the information that you collect, it describes death. It places the deaths in various categories.

Mr. SEDGWICK. Exactly.

Ms. WATERS. So you would have, for example, if I need—well, I will ask you. Do you have information about HIV and AIDS?

Mr. SEDGWICK. Yes, we do, absolutely.

Ms. WATERS. And could you help us? What do you show? What are the numbers?

Mr. SEDGWICK. I actually have that in front of me. The rate of death from AIDS in State prison has dropped 85 percent in the last years of the preceding decade. So from 1995 to 2000, it dropped 85 percent. That compares to the mortality rate from all other illnesses, which has been rising.

The non-AIDS mortality rate in State prisons has risen about 35 percent between 1980 and 2000.

Ms. WATERS. What was your first——

Mr. SEDGWICK. The first statistic was on AIDS deaths the rate has dropped 85 percent in the last 5 years of the 1990's.

Ms. WATERS. Well, what was it in the 5 years before that?

Mr. SEDGWICK. I don't know the specific rate of death, but I could get that information for you, if you would like.

Ms. WATERS. Yes. I mean, I would like to know.

Mr. SEDGWICK. I believe in our——

Ms. WATERS. I would like to know what you are describing when you say it has dropped 85 percent. I don't——

Mr. SEDGWICK. Well, what we do is we would calculate a mortality rate. What is the rate of death from AIDS per certain number of inmates?

And then we would compare the rate in, for example, 1995——

Ms. WATERS. I know how you get there. It is not complete information for us when we are looking at this kind of stuff. So I would appreciate knowing what it was the 5 years previous to.

Mr. SEDGWICK. What the death rate from AIDS was?

Ms. WATERS. Yes.

Mr. SEDGWICK. I would be happy to get that information for you.

Ms. WATERS. And I would like to know raw numbers, the exact numbers, the exact numbers. If there were 100 deaths in the first 5 years and it has dropped 85 percent, I would like to know exactly how many, what the raw numbers were.

Mr. SEDGWICK. So you would like the absolute numbers, as well as the rates.

Ms. WATERS. That is right. That is right.

Mr. SEDGWICK. We can get that for you.

Ms. WATERS. Absolutely. I yield back the balance of my time.

Mr. SCOTT OF VIRGINIA. Thank you. I thank the gentlelady for her questions.

And I would like to thank all of our witnesses for your testimony.

I particularly want to thank Ms. Scott for being with us today. You are using your tragedy to make sure this doesn't happen to anyone else, and we certainly appreciate you being here, as well as all of the witnesses.

Without objection, the hearing is adjourned.

[Whereupon, at 3 p.m., the Subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

PREPARED STATEMENT OF THE HONORABLE JOHN CONYERS, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN, AND CHAIRMAN, COMMITTEE ON THE JUDICIARY

The "Death in Custody Reporting Act of 2000," requires jurisdictions to report any prisoner/inmate/detainee death, and the circumstances surrounding that death to the Justice Department annually. The act expired on 12/31/2006, and is introduced for reauthorization as the "Death in Custody Reporting Act of 2007."

Before the act was passed there was no standardized reporting in the United States and it was suspected that over 1,000 persons died while in custody each year.

Until the law passed in 2000, the only light shed on deaths in custody was by researchers and activists who began focusing on the issue in the early 1980s.

In 1995, after conducting a one-year investigation, the Asbury Park Press of New Jersey ran a series of award-winning editorials that brought the seriousness of the lack of reporting to the nations's attention. The editorials detailed abuses throughout the criminal justice system including racism, overzealous police interrogations, cover-ups and general police incompetence, which prompted Congressional action.

Since the early 1980s and continuing through 2005, the death rate of persons in custody has dropped by 93%.

There is still work to do. BJS states that although prisons and jails have become forthcoming in their reporting, the reporting of deaths of people during arrest and during transport to jail is still suspect. The circumstances surrounding the deaths is not complete and BJS suspects that not all deaths are reported.

We must now focus on improving the law. It has done much to overcome the problems in the institutions but we must widen the focus to police officers affecting arrests and transporting arrestees.

We cannot allow the very officers charged with protecting and serving the public to be unchecked when it comes to the safety of persons in their custody. Whether someone in their custody dies through a violent encounter during arrest, through negligence or for any reason, there must be a proper accounting of the death. Justice demands nothing less.

PREPARED STATEMENT OF THE HONORABLE BETTY SUTTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO, AND MEMBER, SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY

Mr. Chairman, I'm pleased to add my voice in support of H.R. 2908, the "Death in Custody Reporting Act of 2007."

Mr. Chairman, you have been an advocate for the national reporting of in-custody deaths for more than 10 years now, and I admire your dedication in ensuring the public has access to this important information.

Transparency and accountability are standards to which law enforcement agencies at every level of government must aspire. We must have a criminal justice system worthy of the trust of the American people, and we must have law enforcement agencies who consistently meet the highest standards of accountability.

The Death in Custody Reporting Act is an example of how a small change in the law can yield enormous benefits. In the past, lax reporting requirements may have resulted in tragedies that will never find a full explanation. Individuals died in custody without any explanations or records as to why they were there in the first place.

A 1995 investigation in the Asbury Park Press found that approximately 1,000 individuals died in custody each year, many under suspicious circumstances that were poorly documented by those entrusted with their safety.

But after the Death in Custody Reporting Act was passed in 2000, we could for the first time systematically identify the ways in which our criminal justice system fell short.

I am optimistic that with this reauthorization, we can do even more. There is a wealth of information contained in the reports generated under this act, and that presents us with an opportunity for real action leading to real improvements in the administration of justice.

This is common sense legislation and the mechanisms for data collection on in-custody deaths are already in place. The Death in Custody Reporting Act has done a world of good in increasing accountability and it should be reauthorized.

Thank you, Mr. Chairman. I yield back the balance of my time.

HOUSE COMMITTEE ON JUDICIARY
SUBCOMMITTEE ON CRIME, TERRORISM AND HOMELAND SECURITY
BJS DIRECTOR JEFF SEDGWICK
RESPONSES FOR THE RECORD

REP. FORBES

1. Please provide information on how medical causes of death in prison facilities vary across different States.

State prisoner deaths from illness show a great deal of variation from one State to another. Overall, five States had more than 300 illness deaths per 100,000 inmates held, while 10 States had fewer than 150 illness deaths per 100,000 inmates. Louisiana led all States with a rate of 388 illness deaths per 100,000 inmates, followed by Tennessee (344), Pennsylvania (328), West Virginia (326) and Kentucky (323). Vermont had the lowest rate of inmate death from illness (108 per 100,000 inmates), followed by Alaska and Iowa (111 each).

Death rates from specific medical conditions also reflected this wide variation across States. Heart disease death rates varied from 10 per 100,000 in New Hampshire to 189 per 100,000 in West Virginia. Cancer death rates ranged from 0 in Vermont to 103 per 100,000 inmates in Louisiana. Five States had fewer than 10 deaths from liver disease per 100,000 inmates, while eight States had more than 40 per 100,000. For detailed data on these variations, please see Appendix Table 9, page 9 of the BJS report *Medical Causes of Death in State Prison, 2001-2004* (go to: http://www.ojp.usdoj.gov/bjs/pub/pdf/mcdsp04.pdf)

2. Please provide charts outlining the decline in suicide and homicide rates over the last 25 years.

Homicide and Suicide Rates in State Prisons and Local Jails, 1980-2005

Local Jail Inmate Mortality rate, per 100,000 inmates			
	Suicide	Homicide	Source:
1983	129	5	A
1988	85	3	A
1993	54	4	A
1999	54	5	A
2000	47	3	C
2001	50	3	C
2002	47	3	C
2003	43	2	C
2004	42	3	C
2005	38	3	C

State Prison Inmate Mortality Rate, per 100,000 inmates			
	Suicide	Homicide	Source:
1980	34	54	B
1985	26	24	B
1990	16	8	B
1995	16	9	B
2000	16	5	B
2001	14	3	C
2002	14	4	C
2003	16	4	C
2004	16	4	C
2005	17	4	C

A: Census of Jails
B: National Prisoner Statistics Program
C: Deaths in Custody Reporting Program

For more information, visit:
http://www.ojp.usdoj.gov/bjs/dcrp/dictabs.htm

REP. COBLE

1. Please provide information on how these deaths in custody vary by racial categories.

In the extensive data tables BJS recently released on our website regarding deaths in custody, you can find several tables breaking down the number, percentage and rate of deaths across inmate demographic categories. Over the 2001-2005 period, white inmates made up half of all State prisoner deaths (49%), followed by blacks (38%), Hispanics (11%) and those of other or multiple races (2%). The rate of death among blacks (203 deaths per 100,000 State prisoners) and Hispanics (199 per 100,000 State prisoners) were nearly identical in State prisons during this period, but the mortality rate of white inmates (346 deaths per 100,000 inmates) was 70% higher. In particular, white inmates had higher rates of death from the following causes (data are from 2001-2004):

Death rates per 100,000 inmates			
Heart diseases:	whites=102	blacks=56	Hispanics=38
Cancer:	whites=85	blacks=47	Hispanics=39
Suicide:	whites=24	blacks=8	Hispanics=17

While whites had the highest rates of death overall, black inmates had a high rate of AIDS deaths (26 per 100,000 black inmates, compared to 18 per 100,000 Hispanic inmates and 10 per 100,000 white inmates). For more detailed data, please see appendix

table 3 on page 7 of the BJS report *Medical Causes of Death in State Prison, 2001-2004* (go to: http://www.ojp.usdoj.gov/bjs/pub/pdf/mcdsp04.pdf)

Data on the specific medical causes of death has not been analyzed yet for local jail inmates, but in terms of overall mortality rates, similar patterns emerged. During 2000-2002, the overall mortality rates of blacks (118 deaths per 100,000 inmates) and Hispanics (98 per 100,000) were similar in local jails, but white inmates had a much higher rate of death (219 per 100,000). While homicide rates were equal for all racial groups (at 3 homicides per 100,000 inmates), the suicide rate of white jail inmates (96 per 100,000) was six times higher than that for blacks (16 per 100,000) and over 3 times that for Hispanics (30 per 100,000). For more on these rates, please see page 5 of the BJS report *Suicide and Homicide in State Prisons and Local* Jails (go to: http://www.ojp.usdoj.gov/bjs/pub/pdf/shsplj.pdf).

REP. WATERS

1. Please provide clarification (exact raw counts and rates) of the following statement: "the death rate from AIDS in State prison dropped 85% between 1995 and 2000." Please also provide data for the "preceding five years."

Below are the raw counts of AIDS deaths in State prisons, along with rates of such deaths per 100,000 State prisoners held, including DICRA data collected since the drop in 1995-2000 (the more detailed DICRA records allow us to identify more cases of AIDS deaths):

Counts of AIDS deaths in State prisons
1991: 520
1992: 648
1993: 739
1994: 923
1995: 976
1996: 904
1997: 538
1998: 339
1999: 232
2000: 172
2001: 270 (first year of collection under DICRA)
2002: 245
2003: 210
2004: 145
2005: 153

Rate of AIDS deaths, per 100,000 State prisoners
1991: 75
1992: 85
1993: 89
1994: 102

1995: 100
1996: 87
1997: 49
1998: 31
1999: 20
2000: 15
2001: 23 (first year of collection under DICRA)
2002: 20
2003: 17
2004: 12
2005: 12

Much more detailed information on AIDS mortality in State prisons can be found in the BJS report *Medical Causes of Death in State Prison, 2001-2004* (go to: http://www.ojp.usdoj.gov/bjs/pub/pdf/mcdsp04.pdf)

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