Death in Custody

Pennsylvania Democratic Policy Committee

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Verbal Testimony

Introduction/Background

Good afternoon, Senator Katie Muth, Chair of the Pennsylvania Senate Democratic Policy Committee, and Senator Cappelletti for co-hosting a hearing on the Commonwealth's absence of reliable information surrounding deaths in the custody of law enforcement and correctional institutions. As well as realizing that comprehensive reporting of death in custody is critical to the development of public health prevention strategies within the Commonwealth of Pennsylvania.

My name is Dr. Roger A. Mitchell Jr, I am board-certified in forensic pathology, the former Chief Medical Examiner of Washington DC and the former interim Deputy Mayor for Public Safety and Justice in Washington DC. I currently serve as the Chief Medical Officer for Howard University Ambulatory Care and Director of the Center of Excellence for Trauma and Violence Prevention.

It brings me no pleasure to testify today on the problem of Deaths in Custody, but I do appreciate the confidence of the Committee in asking me to do so. I take seriously the task that has been set before me.

Before we get into the specific policy recommendations, I would like to provide some foundational elements related to the role of the medical examiner in the investigation, examination, certification, and reporting of Deaths in Custody. The medicolegal death investigation (MLDI) system in the United States (US) comprises both coroners and medical examiners. As you know, Pennsylvania has a hybrid system. The difference between these types of systems varies based upon the jurisdiction, as a result there is considerable variability in how the MLDI systems are implemented across the nation. In general, coroners are elected officials who do not possess medical education. Medical examiners are board-certified forensic pathologists and are appointed by governmental leadership. Both systems require that sudden and unexpected deaths be reported to ensure proper investigation, examination, and certification. Manner of Death includes homicides, suicides, accidents, undetermined deaths, and natural.

I have been studying Deaths in Custody for 25 years. Deaths of men such as Amadou Diallo (NY) and Earl Faison (NJ) forced me to think about Deaths in Custody as a public health issue. Although much of what we think about when we hear the term "Deaths in Custody" are the recent, prominent cases like the deaths of Elijah McClain and George Floyd, we must remember that Deaths in Custody occur on a continuum. In fact, the majority occur while in jail or prison. Death moves through four (4) distinct phases with the overlap of each period. The Deaths in Custody phases include: 1) pre-arrest related (during pursuit); 2) arrest-related (apprehension and transport); 3) in-custody (in short-term holding, detention, and jail); and 4) incarcerated (long-term jail, detention, or prison). Additional deaths in custody can occur during judicial executions and post-custody (death within one year of release from jail or prison).

LaShawn Thompson

Let me tell you about the death of LaShawn Thompson in Fulton County Jail, Georgia. Just recently I was asked by the Attorneys representing family of LaShawn Thompson along with **Colin Kaepernick's Know Your Rights of Camp Autopsy Initiative** to review his death that occurred in

Fulton County Jail. On Monday September 12, 2022, Mr. Lashawn Thompson was found on the floor unresponsive and slumped over the toilet within his jail cell. He was covered with feces and body lice. The original medical examiner called the manner and cause of death as undetermined. According to the timeline and medical records available, Mr. Thompson received his last dose of schizophrenic medications 32 days before his death. At autopsy, post-mortem toxicology reveals no evidence of the treatment medications in his blood stream. The autopsy findings from Mr. Thompson show a weight loss of 32 lbs. which calculates to a loss of approximately 18% of his body weight over a short period of time. Dehydration, Weight loss, Filthiness, and Body Lice infestation are all evidence of severe neglect. I diagnosed Mr. Thompson's **Cause of Death as Complications due to Severe Neglect with Contributing Cause, Untreated Decompensated Schizophrenia, and the Manner of Death as Homicide.**

Policy Recommendation/Conclusion

It's cases like LaShawn Thompson that remind us of the importance of transparency and oversight for those who die in the custody of our criminal legal system. Transparency begins with the collection of reliable data. Followed by data review and trend analysis, and the development of prevention policy and programming, implementation of prevention strategy and process, and then evaluation. Rinse and repeat.

Death in custody is a public health issue. To ensure that these deaths are prevented we, the National Medical Association, are supporting national efforts to institute two major policy changes at the local state level:

1. The addition of a Death in Custody Check box on the local state death certificate
    a. This is simple checkbox that states "Death in Custody – Yes or No and has sub boxes that read Arrest Related and Incarcerated.
    b. Data boxes on the local and national death certificate has allowed us to understand issue like the impact of smoking on cancer, the frequency of death associated with motor vehicles, and maternal mortality.
2. The second policy change is the formation of the Death in Custody Review Committee.
    a. This is a multidisciplinary committee who has the responsibility to review all death in custody within the state for the purposes of establishing programs and policy to prevent such deaths. The committee should include, but not be limited to, members from the medical examiner/coroner community, emergency room/ICU physicians, educators, public health experts, correctional leadership, and community members who have lost loved ones in the carceral system.
    b. The committee should develop an Annual Report with case-based recommendations to be submitted to the local State Department of Health
    c. The committee should develop an presentation to be provided at an annual hearing in front of the State Legislature

I want to thank you for the opportunity to present to this august body. I apologize that I am not there in person to answer your questions, but I am making arrangements to meet with you in your offices in the upcoming weeks. I have submitted a full report for your review. Please reach out to me directly with any questions via email roger.mitchell@howard.edu

Respectfully with Truth and Service. Thank you.

Death in Custody as a Public Health Issue

Background

Mass incarceration is a major public health issue in the United States of America. In fact, 2023 marks 50 years since the start of the policy that has led to this unique American phenomenon. Since 1973 when then President Richard Nixon declared a "war on drugs" there has been a swift and steady increase in the number of people incarcerated in the United States of America. But it was during the 1980's when the incarcerated population in America began to skyrocket. The total prison population was approximately 329,000 in the early 1980's and essentially doubled to approximately 650,000 by 1990. By 2005 the incarcerated population grew to 1.6 million (Cullen, 2018).

As time has progressed and more and more marginalized and racially minoritized individuals fill the walls of US jails and prisons, the public health, medical, and research communities have been largely silent on the effects the carceral system has on the health of those who encounter it. Whether infectious diseases (i.e. COVID-19, HIV), cardiovascular disease, substance abuse, psychological disorders, or violent injury, justice involved persons tend to have poorer health outcomes (Wang, 2023).

According to the Bureau of Justice Statistics, by the end of 2021, an estimated 5,444,900 persons were under the supervision of adult correctional systems in the United States (4.5M Men and 956K women) In 2021, white persons made up 48% of the total correctional population, while Black persons accounted for 31% and Hispanic persons 16%. In addition, white persons made up the largest portion of the probation, parole, and jail populations from 2011 to 2021, while Black persons accounted for the largest portion of the prison population. This results in an estimated 1 in 19 (5,350 per 100,000) black adult U.S. residents under correctional supervision by the end of 2021(Carson, 2021).

Even though African American and Latinx individuals make up only 30% of the U.S. population, they constitute 56% of those who are housed in our US jails and prisons (Tadros, 2023). Because there is a potential for extreme limitations to providing medical care within a correctional setting. The limitations can be found within the physical plant structure as well as resources for necessary equipment. Limitations within the carceral system, including the lack of specialized equipment and physicians, can lead to a delay in the care of our marginalized and minoritized individuals. (Tadros, 2023).

Those in the custody of the criminal legal system lose much of their self-sufficiency. They are not afforded the choice of their meals, clothing, or housing. They cannot exercise or breathe fresh air and rely on others to ensure their access to healthcare. For instance, justice involved individuals cannot identify a doctor, a dentist, or even seek out their own urgent care for acute pain or injury. Therefore, it is incumbent for the local or federal jurisdiction to provide complete and equitable care to those who are justice involved (Schicker, 2014).

Health care in our correctional institutions is a constitutional right. Those who are wards of the government that cannot seek medical care, treatment, or prevention for their diseases or injuries must be provided with these elements of their livelihood from the government that holds them.

There is such variability in how care is delivered to those who are incarcerated. That variability in care is a source of great inequity. The inequity of healthcare delivery is not just for those who are incarcerated but for those who are returning into the community. (Puglisi, 2017).

Opportunities for Areas of Public Health Oversight and Improvement

Cardiovascular Disease

Cardiovascular Disease has been projected to affect an estimated 12% of the US population by 2030. Inequity along the lines of race and ethnicity exists among those suffering from cardiovascular disease as well as the associated comorbidities such as obesity, diabetes, smoking, high cholesterol. Because nearly 60% of the incarcerated population are considered racial and ethnic minorities who are of lower education and economic status there may be a higher risk of cardiovascular disease of racialized minorities in jail and prison. However, limited research has been conducted to confirm the risk of cardiovascular disease for those incarcerated. Much of the research that has occurred regarding cardiovascular disease burden has focused primarily on the prison population ignoring the jail population. The majority of individuals released back into society are released from jail and therefore a full understanding of cardiovascular risk for the incarcerated must also include evaluation of the jail population (Camplain, 2021).

Cancer

Another area of health inequity suffered among persons who are incarcerated is the late diagnosis of cancer. As has already been described, many individuals who become incarcerated may have limited access to health care and therefore when diagnosed with cancer are more likely than the general population to be diagnosed with cancers at advanced stages. In Rhode Island, the public health system created a collaboration with the correctional health system for colorectal screening. Colorectal cancer (CRC) is one of the leading causes of cancer death (Dumont, 2021). Prevention through screening makes CRC a great target for improving access for those persons who are justice involved. Over the two years of the project staff members determined eligibility for the CRC screening, worked collaboratively with facility leadership to engage patients, designed and distributed survey, and disseminated and collected fecal immunohistochemical tests. The program was successful in not only identifying the patients who were eligible for FIT but 75% of those eligible submitted the FIT specimen. 63% of the patients with positive FIT underwent colonoscopy. The remaining 37% either refused or were released before the colonoscopy could be performed. 6.1% of colonoscopies performed; 3.7% of positive FITs were positive for invasive adenocarcinoma. This is a model approach that should be incorporated in all jails and prisons within the United States of America (Dumont, 2021).

Psychiatry & Substance Abuse

As state and local governments close dedicated psychiatric treatment centers, jails and prisons become the location of choice for the treatment of mental health illness. There is much conversation about the appropriateness of the carceral system as the setting for equitable psychiatric care. Nonetheless, many of those who are incarcerated suffer from associated mental and behavioral health issues. For this reason, it is critical for psychiatric physician training to include care in the carceral system. Psychiatric training in the correctional setting is increasingly important not just for general residency but forensic psychiatric fellows. In fact, forensic fellows have correctional medicine requirements (Hansen, 2017).

In addition to psychiatric illnesses, our jails and prisons have become housing for those who suffer

from substance use disorder. According to the literature approximately 75% of people with serious mental illnesses in the criminal justice system have a co-occurring substance abuse disorder. In fact, it is estimated that as high as 80% of incarcerated men and women have crimes implicating dependence on drugs or alcohol (Shicker, 2014). Substance use and abuse, specifically opioid use disorder in the United Stated carceral system and its treatment, or lack of treatment, is also important to the psychological health of those who are justice involved. The recent area of concern is the access of medical assisted therapy (MAT) for individuals suffering from opioid use disorder (OUD) while incarcerated. Historically, that has been limited access for those suffering from OUD to medications such as methadone, buprenorphine, and naltrexone. MAT is known to decrease morbidity and mortality among those enrolled in treatment. Nonetheless, there are few state-based programs that ensure access to medically assisted therapy for those suffering from OUD. Recent work done in Massachusetts describes the importance of policy and legislation when mandating implementation of MAT for OUD. In fact, Massachusetts was the first state in the nation to mandate the provision of MAT for OUD in jails. Those tasked with implementation of identified barriers in the service environment, funding of the program, the system-based characteristics of the patients receiving the treatment, treatment monitoring, and organizational leadership (Pivovarova, 2022).

Women's Health

The public discourse, or lack thereof, surrounding equity in health care delivery within the carceral system usually describes the morbidity and mortality of men. Gender inclusion and reproductive health are even lower on the list of topics to discuss. As the result of the recent SCOTUS decision regarding reproductive health and a woman's right to abortion, there is an increasing need to understand reproductive health equity among incarcerated women. Every year thousands of women enter the carceral system pregnant. Prior to the SCOTUS decision incarcerated women maintained their right to access to abortion, but even then, there was not equitable distribution of this right across states. Now, it becomes even more of a question of the level of access that women may have to reproductive health including abortion during incarceration (Sufrin, 2021).

Medicaid Inmate Exclusion Policy

One of the main issues of concern is the absence of health insurance for those who are incarcerated. The standards for correctional medicine have been historically and largely unable to be enforced due to the effects of the of the Medicaid Inmate Exclusion Policy (MIEP) established in 1965 (Jolin, 2023). Incarcerated people are excluded from Medicaid coverage due to this provision in the Social Security Act Amendments of 1965 (Edmonds, 2021). Even in the 26 states that expanded Medicaid services as part of the Affordable Care Act (ACA), many people have their Medicaid enrollment terminated upon incarceration, such that most are released without Medicaid and need to reapply. Even though there is a growing movement for states to suspend vs. terminate the Medicaid benefit upon incarceration, there is no opportunity for those who are incarcerated to access the insurance benefit. Despite the fact that 95 percent of the incarcerated population is released back into the community, basic health insurance is not available to those who are incarcerated (Puglisi, 2017). This is a matter of equity.

There are nearly 650,000 people released from prison and more than 10 million admitted to local jails annually (Albertson, 2020). Medicaid is an important form of health insurance coverage for several hundred thousand justice-involved individuals each year. Citizens returning to community after incarceration often have lower socioeconomic status and educational attainment compared to the general population. The reality of the returning citizen is not only lack of access to education

and economics but often access to healthcare is also limited. In fact, it has been reported that approximately 80 percent of people released from prison have some chronic condition including medical, psychiatric, or substance use making continuity of care even more important (Shavit, 2017). Often the priority of those returning from incarceration is attaining a job, food, and shelter, rightfully so. Thus, resulting in deprioritizing treatment for their chronic conditions. In fact, many of those returning from incarceration seek medical care in emergency departments versus fully developed community health care systems. Care coordination between the carceral system and the community primary care system becomes critical if the public health care system is dedicated to improving health equity outcomes for those involved in the criminal legal system (Shavit, 2017).

The Medicaid coverage gaps that are created by the Medicaid Inmate Exclusion Policy do not just impact adults. In fact, compared with the justice-involved adult population, justice involved youth are just as impacted upon reentry into the community. There are several solutions to counteract the MIEP that can improve access to post-custody care for both adults and youth. These include: leaving Medicaid activated, reactivating the Medicaid benefit before reentry, improve communication with the private/public healthcare systems for patient reentry, and address the social determinants that may exist in the family prior to return of the incarcerated patient (Scannell, 2022).

Potential Public Health Partnerships

There are multiple public health partnerships that can be leveraged to engage the above priority areas.

National Medical Association
www.nmanet.org

The National Medical Association (NMA) is the collective voice of African American physicians and the leading force for parity and justice in medicine and the elimination of disparities in health. The National Medical Association (NMA) is the largest and oldest national organization representing African American physicians and their patients in the United States. The NMA is a 501(c) (3) national professional and scientific organization representing the interests of more than 50,000 African American physicians and the patients they serve. NMA is committed to improving the quality of health among minorities and disadvantaged people through its membership, professional development, community health education, advocacy, research and partnerships with federal and private agencies. Throughout its history the National Medical Association has focused primarily on health issues related to African Americans and medically underserved populations; however, its principles, goals, initiatives and philosophy encompass all ethnic groups.

The NMA has been leading the charge on Death in Custody. https://www.nmanet.org/page/Fact-Sheets

Physicians for Human Rights
https://phr.org

For more than 35 years, Physicians for Human Rights (PHR) has used science and the uniquely credible voices of medical professionals to document and call attention to severe human rights violations around the world. We investigate and document human rights violations, give voice to survivors and witnesses, and plant seeds of reconciliation by ensuring that perpetrators can be held accountable for their crimes. We believe that medical ethics are deeply bound to the protection of human rights. PHR uses our core disciplines – science, medicine, forensics, and

public health – to inform our research and investigations and to strengthen the skills of frontline human rights defenders. We work closely with hundreds of partners around the world, using facts to wage effective advocacy and campaigning and providing critical scientific evidence so that survivors can seek justice.

PHR recently authored a report on Excited Delirium. https://phr.org/our-work/resources/excited-delirium/

American Public Health Association
www.apha.org
APHA serves as a convenor, catalyst and advocate to build capacity in the public health community. We champion optimal, equitable health and well-being for all. We speak out for public health issues and policies backed by science. We are the only organization that combines a 150-year perspective, a broad-based member community and the ability to influence federal policy to improve the public's health. APHA publishes the *American Journal of Public Health* and *The Nation's Health* newspaper. At our Annual Meeting and Expo, thousands of people share the latest public health research. We lead public awareness campaigns such as Get Ready and National Public Health Week.

The APHA has been involved in several initiatives that supports the work to end death in custody. https://www.apha.org/Search-Results?q=death%20in%20custody

Hip Hop Caucus
https://hiphopcaucus.org/
Our mission is to use the power of our cultural expression to empower communities who are first and worst impacted by injustice.
Our vision is racial justice, healthy communities, and a healthy planet.
Throughout our history, Hip Hop Caucus has mobilized hundreds of thousands of young BIPOC voters across seven election cycles, produced HOME (Heal Our Mother Earth) – the first climate album to move over 60,000 people to action in support of the Clean Power Plan in 2014, and led the first protest in New Orleans after Hurricane Katrina and continually partnered with local organizations for annual commemorations.
In 2021, our community took over 2.1 million actions on climate justice with Think 100% including petition signatures, EPA comments, event participation, social media post engagement, and more. We played an influential role as a national partner to the local Memphis community in the cancellation of the Byhalia Pipeline. We also raised and distributed $100,000 in direct relief to families affected by Hurricane Ida across 12 parishes in Louisiana.

Hip Hop Caucus is the producer of the podcast Official Ignorance that centers around Death in Custody as a Public Health Issue. https://hiphopcaucus.org/story/official-ignorance-the-death-in-custody-podcast/

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