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Expertise

Thank you for the opportunity to submit testimony on the issue of deaths in custody in the Commonwealth of Pennsylvania.

My name is Jay D. Aronson. I am the Founder and Director of the Center for Human Rights Science at Carnegie Mellon University in Pittsburgh, PA. I am also Professor of Science, Technology, and Society in the Department of History there. I am also an official visitor with the Pennsylvania Prison Society.

For the past two decades, I have been conducting research on the interactions of science, technology, law, and human rights in a variety of domestic and international contexts. I have received awards, grants, and honors for my work from the National Science Foundation (NSF), National Institutes of Health (NIH), National Endowment for the Humanities (NEH), the MacArthur Foundation, the Oak Foundation, and the Open Society Foundations, among others. My teaching focuses primarily on U.S. public policy. I routinely offer classes on the history of health care and health insurance, immigration, war crimes and human rights violations, and most importantly in this context, policing and law enforcement.

For the last six-and-a-half years, I have been researching deaths in prisons and jails in the United States and recently co-authored a book on the subject with Dr. Roger A. Mitchell, Jr., who will also be offering testimony as part of this hearing. Our book, *Death in Custody: How America Ignores the Truth and What We Can Do about It* (Johns Hopkins University Press, 2023), is a comprehensive analysis of crisis of custodial deaths across the country. It identifies systemic barriers that have impeded accurate counting and investigations at the federal, state, and local levels.

My research on deaths in prisons and jails, and my work with the Prison Society, has included: visiting correctional facilities; meeting with correctional staff, families of the deceased, government officials, public health experts, and journalists; and reviewing numerous accounts of jail and prison deaths, government reports, autopsy reports, news articles, statistics, and official government meeting minutes. Additionally, I have reviewed jail policies and procedures concerning jail death such as notifications, reviews, documentation, investigations, and reporting. The scope of my research covers custodial deaths in Pennsylvania, other states, and in the federal context.

As such, I have specialized knowledge and experience on deaths in prisons and jails in the US, particularly the counting, investigation, notification, and reporting of in-custody deaths.

The Problem in Pennsylvania

When people enter jail or prison, they become invisible to society. When they die in custody, their deaths are all too easy to cover up or even erase completely. Without effective oversight and scrutiny, prisons and jails become death chambers for people never sentenced to death.

In theory, the federal Death in Custody Reporting Act of 2013 requires states to gather and report to the federal government deaths in state prisons and county jails. In practice, the lack of political will and various bureaucratic failures mean that this requirement no longer is enforced. Since 2019, federal death-in-custody have little value.

The system is broken. Enforcement mechanisms don't work and an absolutely infuriating bureaucratic snafu prevents statisticians from the Department of Justice Bureau of Justice Statistics from assisting staff of the Bureau of Justice Assistance with the gathering and analysis of data about deaths in custody.

In the absence of strongly enforced legal requirements to report deaths in custody to the federal government, local law enforcement agencies, jails, and prisons now decide which deaths they want to report and which they don't. Unfortunately, most states do not empower their administering agencies (in our case, the Pennsylvania Commission on Crime and Delinquency) to proactively collect data; instead, they simply accept what local agencies and facilities tell them happened. This means we have a woefully incomplete picture of mortality rates in the criminal legal system.

The problem is most severe in the context of county jails, especially in states like Pennsylvania, which operate largely as independent fiefdoms controlled exclusively by local sheriffs and county administrators. They answer only to themselves and are subjected to very little outside scrutiny.

Journalists Joshua Vaughn (PennLive) and Brittany Hailer (formerly of the Pittsburgh Institute for Nonprofit Journalism, now with the Marshall Project) have done heroic work covering jail deaths in Pennsylvania, thanks in part to a grant from the Pulitzer Center for Crisis Reporting, which allowed them to construct the most complete database of Pennsylvania jail deaths that has ever been assembled.

In a recent analysis, Vaughn found that only 25 of the 56 known deaths of people incarcerated in county jails in 2020 were reported to the federal government. Making matters worse, only 47 of the 56 deaths were even reported to the State Department of Corrections. He showed that the situation improved only slightly for 2021, with 44 of 67 total Pennsylvania jail deaths being reported to federal authorities.[1]

[1] Joshua Vaughn, "Most deaths in Pa. jails went unreported despite rules: 'It is appalling'," PennLive.com, February 9, 2022, https://www.pennlive.com/news/2022/02/most-deaths-in-pa-jails-went-unreported-despite-rules-it-is-appalling.html.

At least part of this discrepancy can be explained by the fact that many county jail officials thought they were not obligated to report the deaths of people who died in a hospital but were released specifically so that they did not die in jail. But pushing a person out of jail as they take their last breath is not a legitimate reason to avoid reporting the death.

The implications of this situation are profound. If reporting is not required in all cases involving a jail- or prison-related death, it is impossible to know, for example, whether poor medical care or the denial of care contributes to the deaths of substantial numbers of incarcerated people. Policy makers and human rights advocates will not know where to focus in seeking to reduce the deadliness of carceral facilities. The omission of data will also further obscure an already hidden problem.

I want to stress once again that we know how many people died in our state's jails last year not because of the work of any government agency or institution, but because of the work of two amazing local journalists being supported by a donor outside the state. This situation is clearly unacceptable in a democratic society that respects the rule of law and upholds basic human rights.

We have come to the point when it is clear that we cannot depend upon law enforcement to police itself. Something needs to change.

Solutions for Pennsylvania

We need to treat death in custody as a matter of public health. We know how many people die in traffic accidents, from tobacco use, as a result of pregnancy and childbirth, and on the job. We have this data because we collect it through checkboxes on the US Standard Death Certificate.

The U.S. death investigation system is by no means perfect, and Pennsylvania's coroners and medical examiners face an array of economic and procedural challenges, but it is indisputable that the system is capable of accurately and reliably recording deaths in custody.[2]

I am urging the Commonwealth of Pennsylvania to **add a death-in-custody checkbox to our state death certificate**, which at minimum requires death certifiers to record whether the death occurred in law enforcement custody, and, if possible, contains additional entries that allow for other kinds information to be collected as agreed upon by relevant stakeholders.

[2] For an excellent overview of the state of the medicolegal death investigation system in Pennsylvania, see: Harry D. Holt, Ph.D., J.D., MBA, Ramona Stone, Ph.D., MPH, and Christina VandePol, MD, "Coroner/Medical Examiner Services in Pennsylvania," Center for Rural Pennsylvania, August 2022, https://www.rural.pa.gov/getfile.cfm?file=Resources/reports/assets/249/Coroner%20Services%20in%20PA%202022.pdf&view=true.

Washington, DC has had a death-in-custody checkbox on its death certificate since 2015 and this change has proven beneficial in more accurately recording these deaths. The checkbox has not created an undue burden on the medical examiner's office, nor has it led to significant complaints from law enforcement agencies or facilities. Because Dr. Mitchell was responsible for implementing this checkbox when he was the city's chief medical examiner, I will allow him to testify about it.

Even with a formal checkbox death, certifiers will not uniformly record and investigate deaths in law enforcement custody on their own. Further, emergency-room physicians generally don't know to ask if a person who is brought in with a seemingly natural illness, after an accident, or in a drug-induced crisis has had any recent interactions with the criminal legal system.

This is why Pennsylvania also needs to implement a **standardized approach to recording and investigating deaths in custody**. **The National Association of Medical Examiners' position statement on best practices in death-in-custody investigations ought to be adopted as standard practice at the state level** to ensure that the autopsy and death investigations are conducted to the highest possible medical standards.[3]

Even when death certifiers do know that they are dealing with a death-in-custody, they may feel pressured to obfuscate the circumstances of these deaths by ruling them as of natural, undetermined, or accidental manner when the person would not have died without interaction with law enforcement. Therefore, another crucial layer in the system Dr. Mitchell and I are proposing is the creation of the kind of **mortality review panels that we have for maternal mortality and infant mortality**, in many states and regions, as well as at the federal level. These panels not only review particular cases, but also ensure that the checkbox is being used appropriately and that the data gathered are accurate and reliable. This is necessary to ensure the integrity of the system. I would argue that the Pennsylvania's death-in-custody review panel should be give the mandate to examine each and every case of homicide, suicide, and undetermined deaths plus a random sample of deaths deemed natural by certifiers. This will ensure that any big problems at the facility- or agency- level are identified and hopefully corrected.

There is, of course, no guarantee that the checkbox or even the review panel to ensure that death certifiers investigate the cause and manner of a death in custody thoroughly in every case, but the checkbox will require them to note that the death did indeed occur in custody. *Even if substandard investigation occurs, and the review panel does not pick up a mistake or intentional obfuscation, the checkbox will alert journalists, human rights advocates, and families that more work may need to take place to find the truth*, including a second autopsy or review by a forensic pathologist well-versed in death-in-custody cases.

[3] Roger A. Mitchell, et al., "National Association of Medical Examiners Position Paper: Recommendations for the Definition, Investigation, Postmortem Examination, and Reporting of Deaths in Custody," *Academic Forensic Pathology*. 2017;7(4):604-618. doi:10.23907/2017.051.

The checkbox is one of **many layers in a system of oversight** designed to hold the criminal legal system accountable for deaths that occur in its custody and provide public health practitioners with the information they need to reduce these deaths. At the moment, we as a society are flying blind.

Reform of the Medicolegal Death Investigation System

Although it is a somewhat tangential to the subject matter of this hearing, I must to end my testimony by suggesting that the Commonwealth of Pennsylvania begin to transition from the coroner system to the medical examiner system in whatever way the state deems most effective and efficient. Coroners, who are elected officials and rarely have training in the science of death investigation, preside over death investigations in 64 of 67 Pennsylvania counties and for almost all of the state's rural residents. The medical examiner system is preferable to the coroner system for many reasons, not least of which because it requires formal training in forensic pathology for the person in charge of the office as well as for the people who work there. This is especially important when deaths are unexpected, unexplained, or suspicious. Medical examiner offices perform their own autopsies and do not have to contract out this vital public function, which coroner's offices have to do.[4]

It certainly won't be possible to replace every coroner with a medical examiner in Pennsylvania, but a regional medical examiner system might make sense to complement the three existing medical examiner offices in Allegheny, Delaware, and Philadelphia Counties. There are many models available across the country and Pennsylvania should be begin to look for ways to phase out the outdated coroner system.

Conclusion

Law enforcement agencies and government officials have failed to produce accurate public records on deaths in custody, both at the federal level and in Pennsylvania, because they either don't care or don't want to do anything about the problem. It is a case of deliberate indifference and official ignorance. The good news is that we can do something about it by adding a death-in-custody checkbox to the Pennsylvania death certificate, enforcing standardized reporting and investigation of deaths in custody, creating a state-level custodial death review panel that ensure accurate and reliable reporting and analyze the data gathered through the checkbox, and, eventually, by reforming the medicolegal death investigate system in our state.

[4] Becky Metrick, "Coroners don't do autopsies and other quirks of Pa.'s death-investigation system," PennLive.com, Jun. 18, 2021, https://www.pennlive.com/news/2021/06/coroners-dont-do-autopsies-and-other-quirks-of-pas-death-investigation-system.html.