Death In Custody:
A Call for Uniformity of Practice

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Professor and Chairman
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Howard University Hospital


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OBJECTIVES

Participants will be able to:

1. Discuss the history and development of the Deaths In Custody Reporting Act

2. Describe the categories of Death In Custody and the importance of uniformity

3. Assess the Manner of Death application for Death in Custody cases

Photo illustration by Elizabeth Brown. Photo from Getty Images.

Ethan Corey

Jun 24, 2020

SHARE

HOW THE FEDERAL GOVERNMENT LOST TRACK OF DEATHS IN CUSTODY

The Department of Justice is leaving researchers, policymakers, and advocates in the dark about deaths in police custody, prisons, and jails.

Amid protests against police violence in the wake of George Floyd's death at the hands of Minneapolis police officers, politicians have embraced calls for more data about police use of force.

Democratic members of Congress released a proposal on June 8 calling for the creation of a nationwide registry of police misconduct along with

JOURNALISM SPURS INTEREST IN DEATH IN CUSTODY

- The issue gained national attention in 1995, when Mike Masterson, then an investigative journalist at the Asbury Park Press in New Jersey, used press reports to estimate that more than 1,000 people had died in local jails nationwide during a four-month period, many under suspicious circumstances. Shocked that no official data existed on in-custody deaths, he traveled to Washington, D.C. to distribute copies of his article to members of Congress.

OPINION

MIKE MASTERSON

DEATHS IN CUSTODY REPORTING ACT 2000

- In 2000, Congress passed the Death in Custody Reporting Act of 2000 (H.R. 1800; Public Law 106-297) which created a program requiring states to report on the **deaths and circumstances of those deaths of any prisoners in their custody**. The Bureau of Justice Statistics continued to collect this information even after the law expired in 2006. This bill would continue that program and extend it to federal prisoners. It would also require the Attorney General to analyze the data and try to find a way to reduce those deaths, then report on it to Congress.

Mortality in Correctional Institutions (MCI) (Formerly Deaths in Custody Reporting Program (DCRP))

Data Collection Status: Inactive

Frequency:

Annually starting in 2000 for jails; 2001 for state prisons; deaths in the process of arrest from 2003 to 2014

Latest Data Available: 2017

https://bjs.ojp.gov/data-collection/mortality-correctional-institutions-mci-formerly-deaths-custody-reporting-program

DATA COLLECTED BY THE BUREAU OF JUSTICE STATISTICS

- Collects inmate death records from each of the nation's 50 state prison systems, Federal Bureau of Prisons, and approximately 2,800 local jail jurisdictions. Between 2003 and 2014, BJS also collected data on persons who died while in the process of arrest.
- Death records include information on decedent personal characteristics (age, race or Hispanic origin, and sex), decedent criminal background (legal status, offense type, and time served), and the death itself (date, time, location, and cause of death, as well as information on the autopsy and medical treatment provided for any illness or disease).
- Due to concerns regarding data quality and coverage issues, **BJS temporarily suspended the arrest-related death (ARD) portion of the DCRP in 2014**.

BJS finished collection of deaths that occurred during the 2019 calendar year in December, 2020, and

formally closed the MCI collection on March 31, 2021

Highlights

- In 2019, a total of 3,853 prisoners died in state prisons or private prison facilities under a state contract, a decrease of 284 deaths from 2018.
- The number of federal prisoners who died in the custody of a facility operated by the Federal Bureau of Prisons (BOP) increased from 378 in 2018 to 381 in 2019.
- The mortality rate was higher in state prisons (330 per 100,000 state prisoners) in 2019 than in BOP-operated facilities (259 per 100,000 federal prisoners).
- Almost 87% of the 65,027 state prisoners and 89% of the 7,125 federal prisoners who died in custody from 2001 to 2019 died of illness.
- The number of deaths in state prisons due to drug or alcohol intoxication increased from 35 in 2001 to 253 in 2019.
- In 2019, adult U.S. residents were more than twice as likely as state prisoners to die from alcohol or drug intoxication, while state prisoners were almost three times as likely as U.S. residents to die by homicide.

FIGURE 1

Number of unnatural deaths of state prisoners, by cause of death, 2001–2019

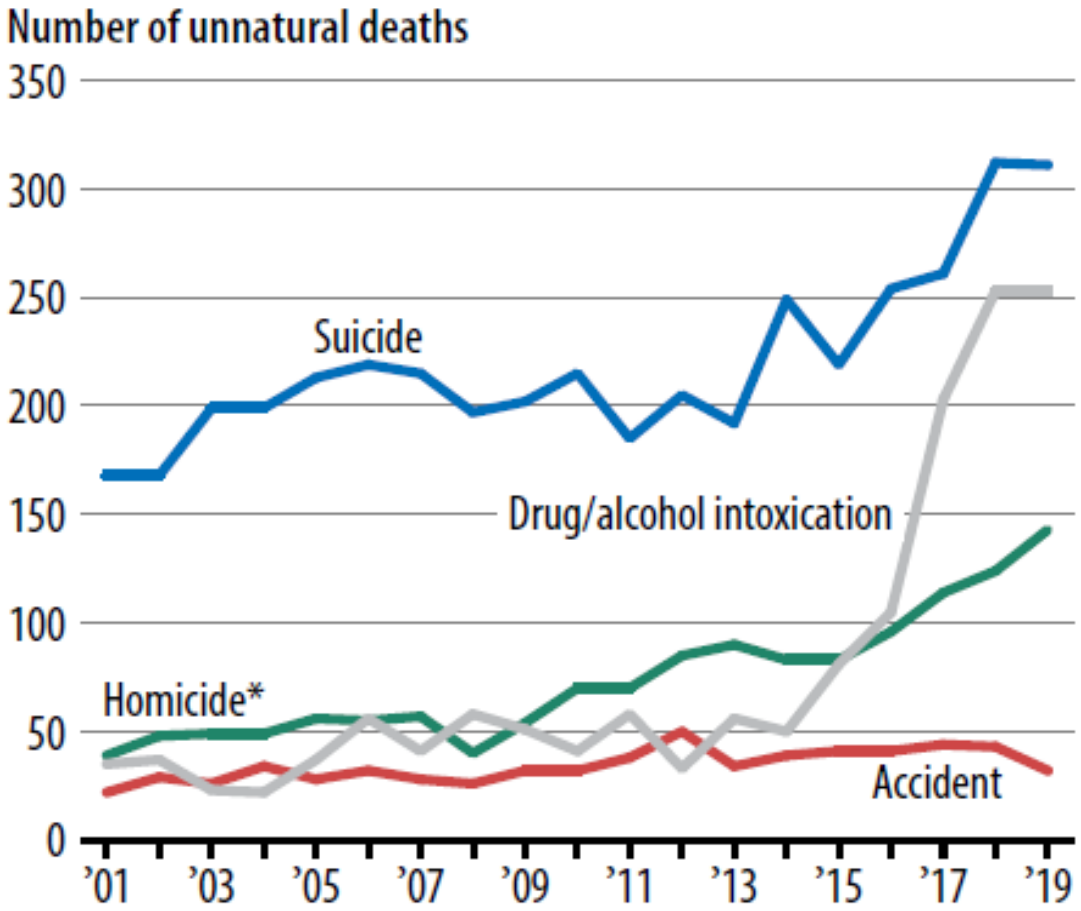
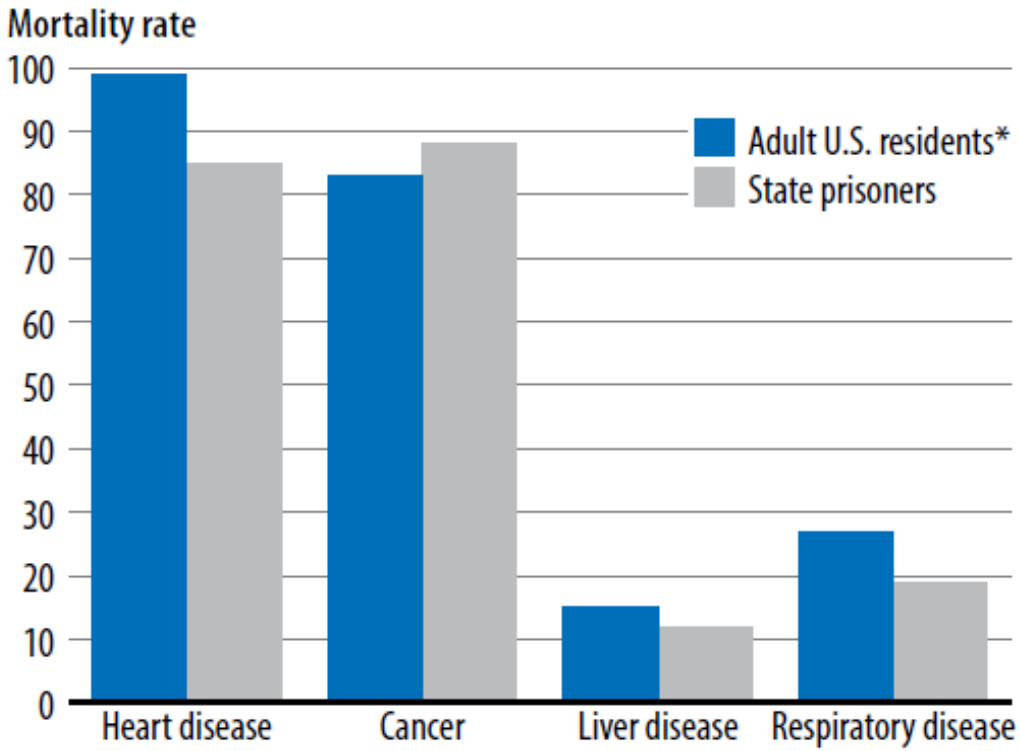


FIGURE 3

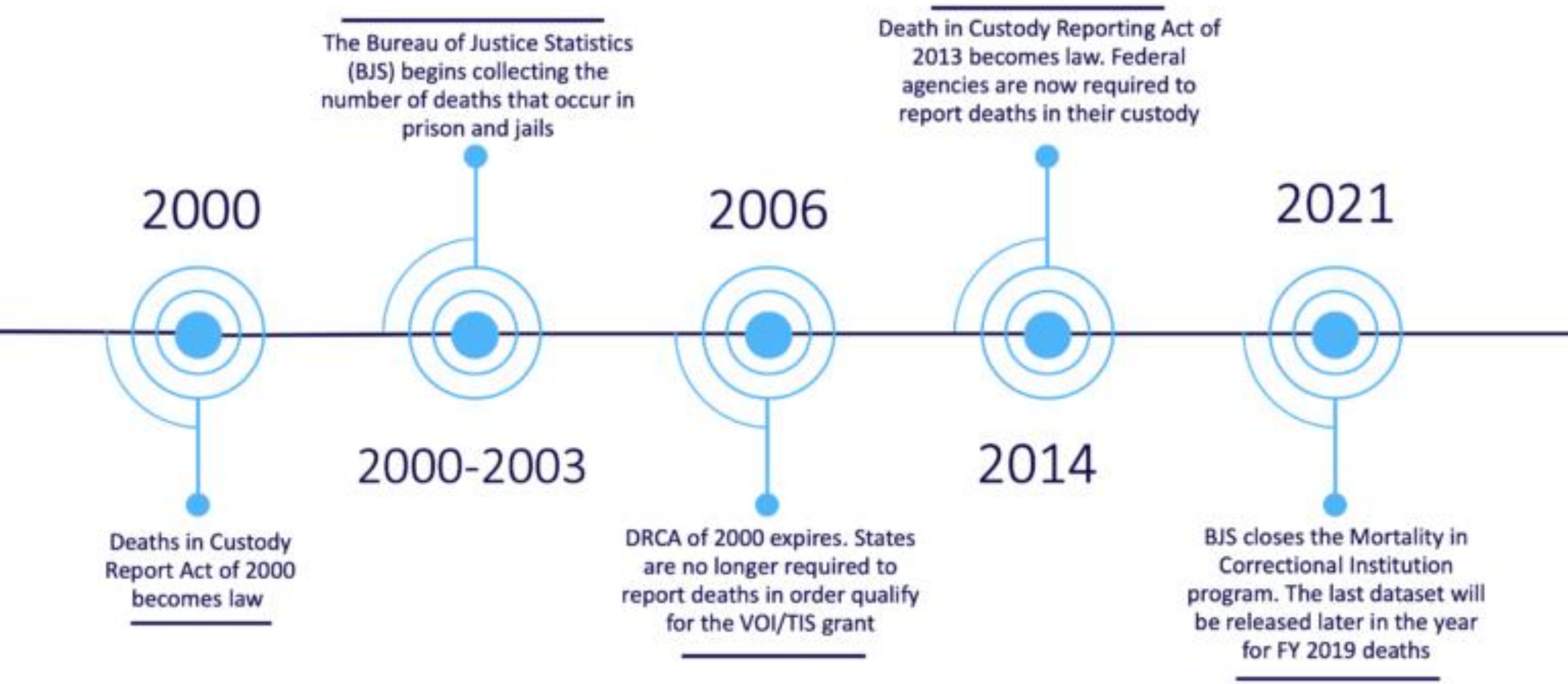
Adjusted illness mortality rate per 100,000 U.S. residents, by cause of death, 2019



Total prison deaths, 2001–2019

- A total of 65,027 state prisoners and 7,125 federal prisoners died while in custody during 2001–19 **(table 1)**.
- During 2001–19, cancer and heart disease accounted for more than 53% of all state prison deaths.
- There were 4,183 deaths by suicide in state prisons and 342 in federal prison facilities operated by the BOP during 2001–19.

DEATH IN CUSTODY REPORTING



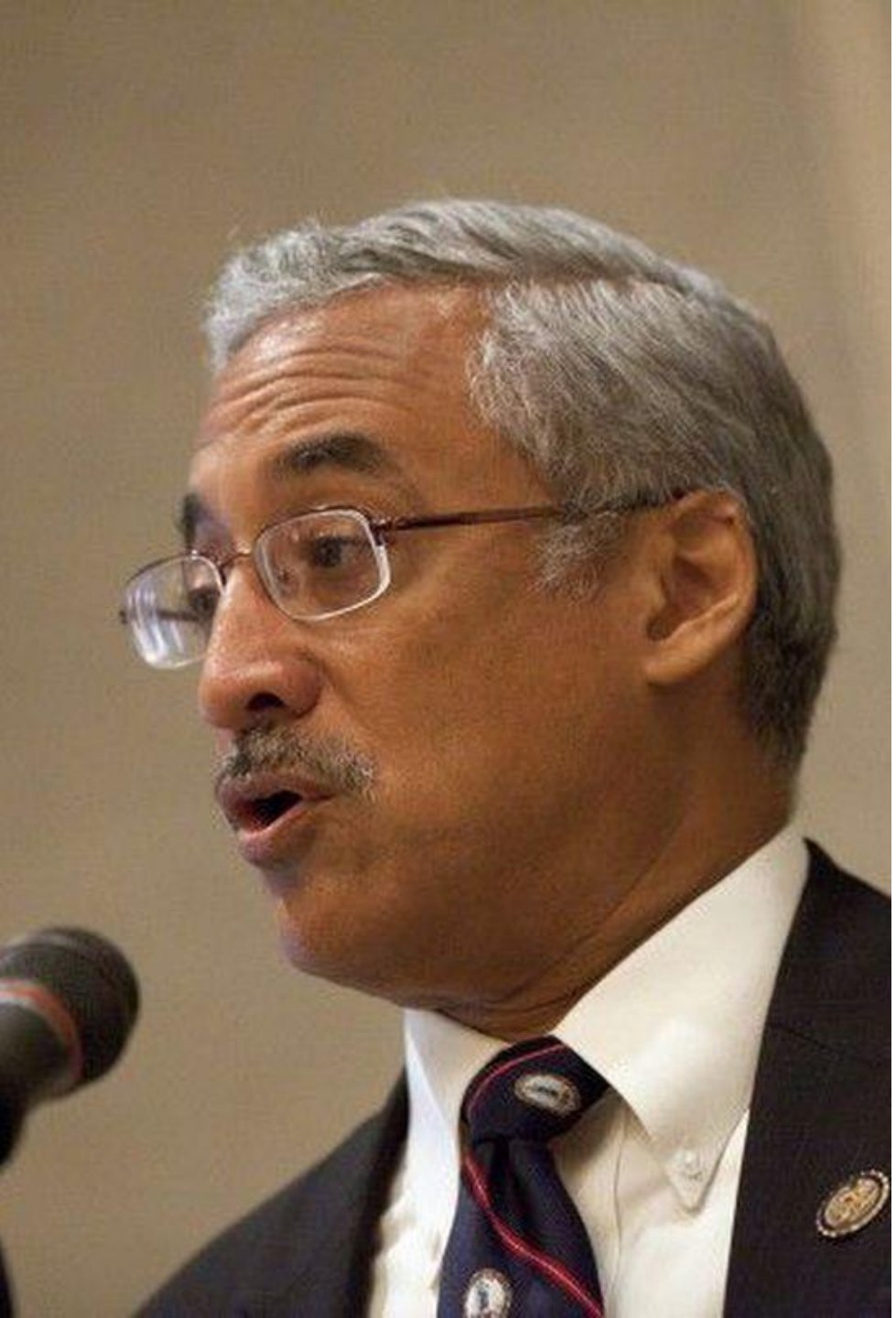
BJA

Bureau of Justice Assistance
U.S. Department of Justice

DEATH IN CUSTODY REPORTING ACT

REPORTING GUIDANCE AND FREQUENTLY ASKED QUESTIONS

Version 3.0; revised March 2022



Federal Policy

- According to the Death in Custody Reporting Act of 2013 (HR 1447), the States are encouraged to report to the Attorney General information regarding:
  - *… the death of any person who is detained, under arrest, or is in the process of being arrested, is en route to be incarcerated, or is incarcerated at a municipal or county jail, State prison, State run boot camp prison, boot camp prison that is contracted out by the State, any State or local contract facility, or other local or State correc- tional facility (including any juvenile facility)*

Federal Policy(cont.)

HR1447

Purpose of the Federal Policy

- The information obtained shall be used to

  (1) determine how it can be used to reduce the number of such deaths; and

  (2) examine the relationship, if any, between the number of such deaths and the actions of management of such jails, prisons, and other correctional facilities relating to such deaths.

Phases of In-Custody

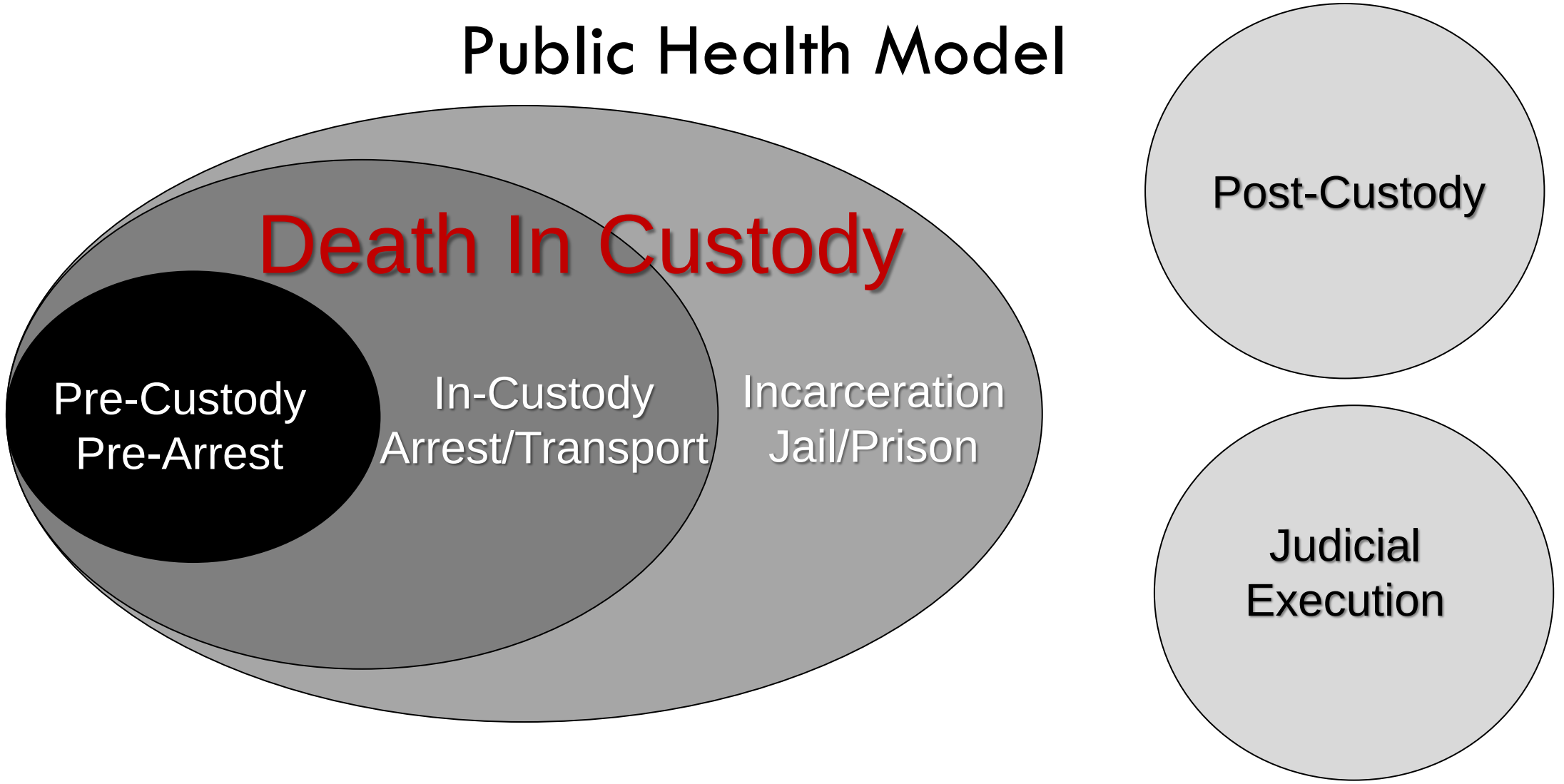
Deaths In Custody

Definitions

- Deaths in Custody can be separated into four (4) distinct phases
  - Pre-Custody: deaths that occur during apprehension, or pursuit.
  - In-Custody: deaths that occur during restraint, transport, or booking/intake/holding.
  - Incarceration: deaths that occur while in jail or prison.
  - Judicial Execution: deaths purposefully conducted by the criminal justice system

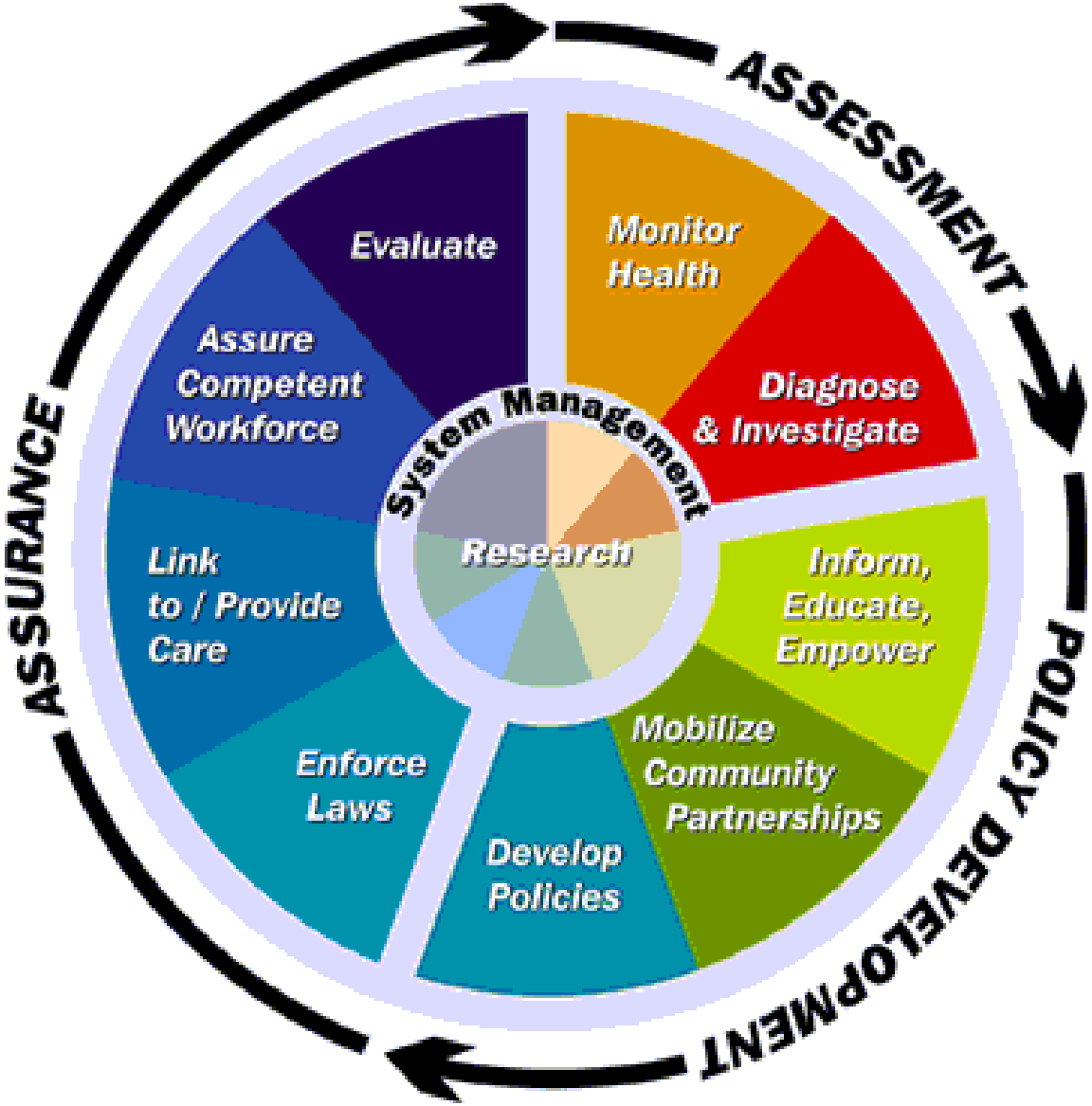
Note: There may be overlap of these phases, therefore the medical examiner must carefully review all records prior to making this distinction.

Public Health Model



DATA COLLECTION, EVALUATION, ANALYSIS & PREVENTION AT EVERY PHASE

DEFINING DEATH ACCORDING TO PHASE ALLOWS FOR PUBLIC HEALTH REPORTING AND DATA COLLECTION ACROSS ALL MANNERS OF DEATH.

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RESEARCH
GUN
VIOLENCE
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PRIORITY
Criminal Justice
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A project of the **RAND Corporation**, the **Police Executive Research Forum**, **RTI International**, and the **University of Denver**

Caring for Those in Custody

Identifying High-Priority Needs to Reduce Mortality in Correctional Facilities

Joe Russo, Dulani Woods, John S. Shaffer, Brian A. Jackson

Roger Mitchell
Office of the Chief Medical Examiner, District of Columbia

Compared with the general population, inmates disproportionately suffer from a variety of serious conditions.

Key Findings

An expert panel of prison and jail administrators, researchers, and health care professionals identified the following as high-priority needs for ensuring the health and safety of inmates in correctional facilities:

- Facilities should provide medical and mental health services at a community-level standard of care.
- Correctional facilities need to better manage organizational and cultural conflicts between security and care objectives.
- There is a need for greater capacity for medical, mental health, and substance abuse care, both within facilities during incarceration and in the community after release.
- The availability of medication-assisted therapies and drug overdose countermeasures should be expanded.
- There is a need for more-uniform adoption of best practices in suicide risk assessment and prevention.
- More and better data are required in order to develop targeted interventions to reduce mortality.
- Compliance with national standards for medical screening and care provision should be better incentivized and supported.
- There is a need for uniformity in how internal death reviews are conducted, including multidisciplinary participation.
- There is a need for more-effective discharge planning and "warm hand-offs" to community-based health providers.
- Greater electronic information sharing between and among correctional institutions and community-based health providers can improve care and reduce inmate mortality.

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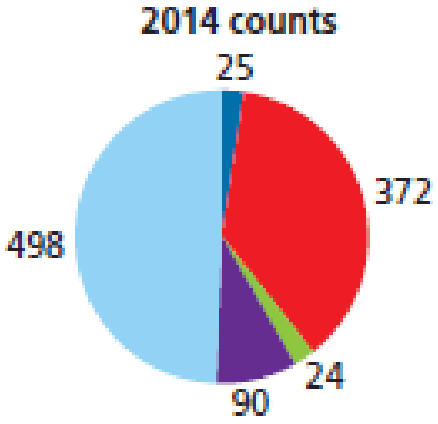
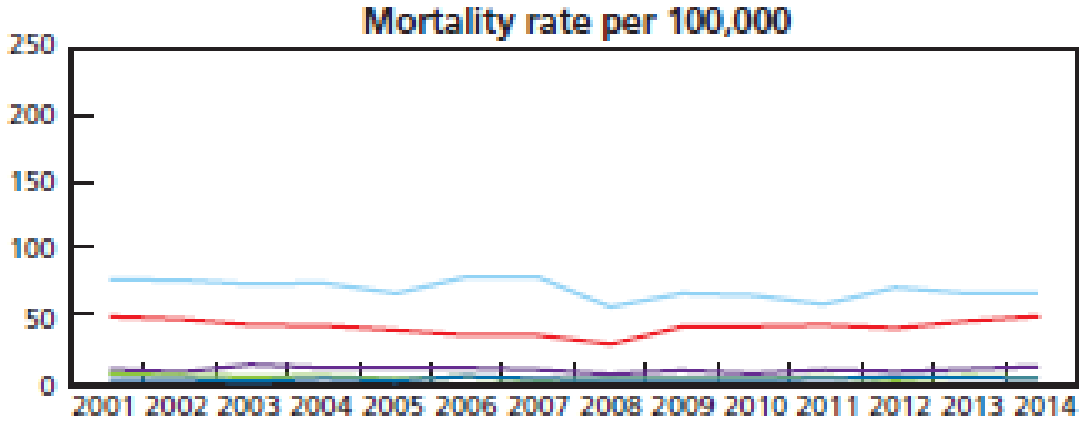
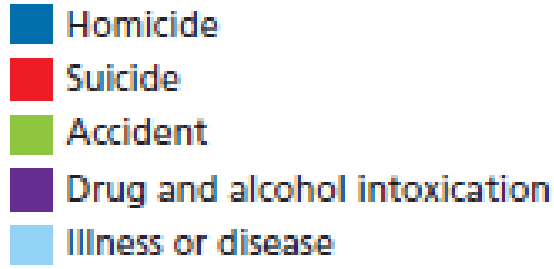
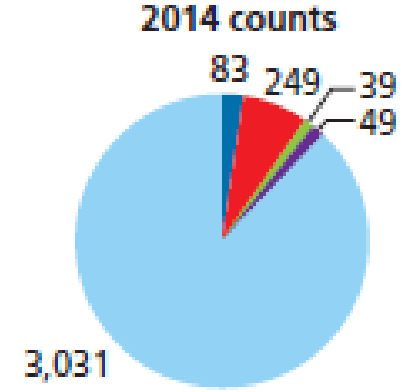
Jails

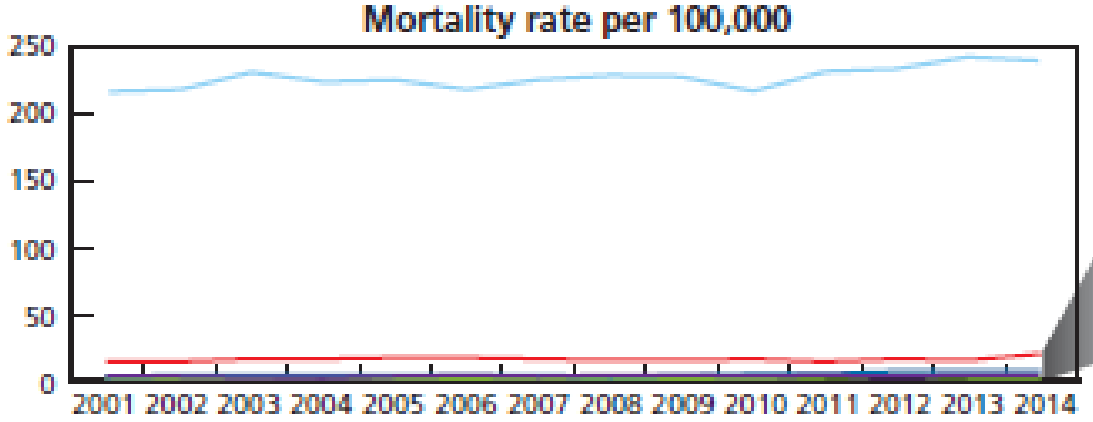


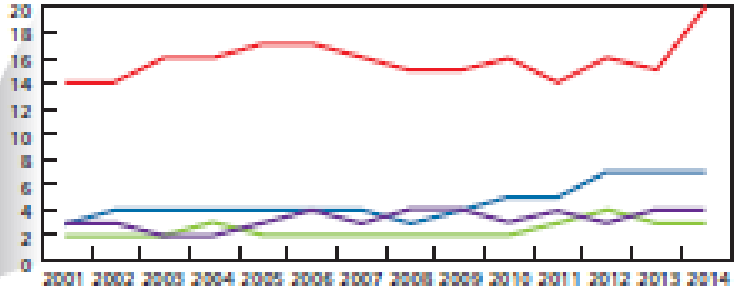


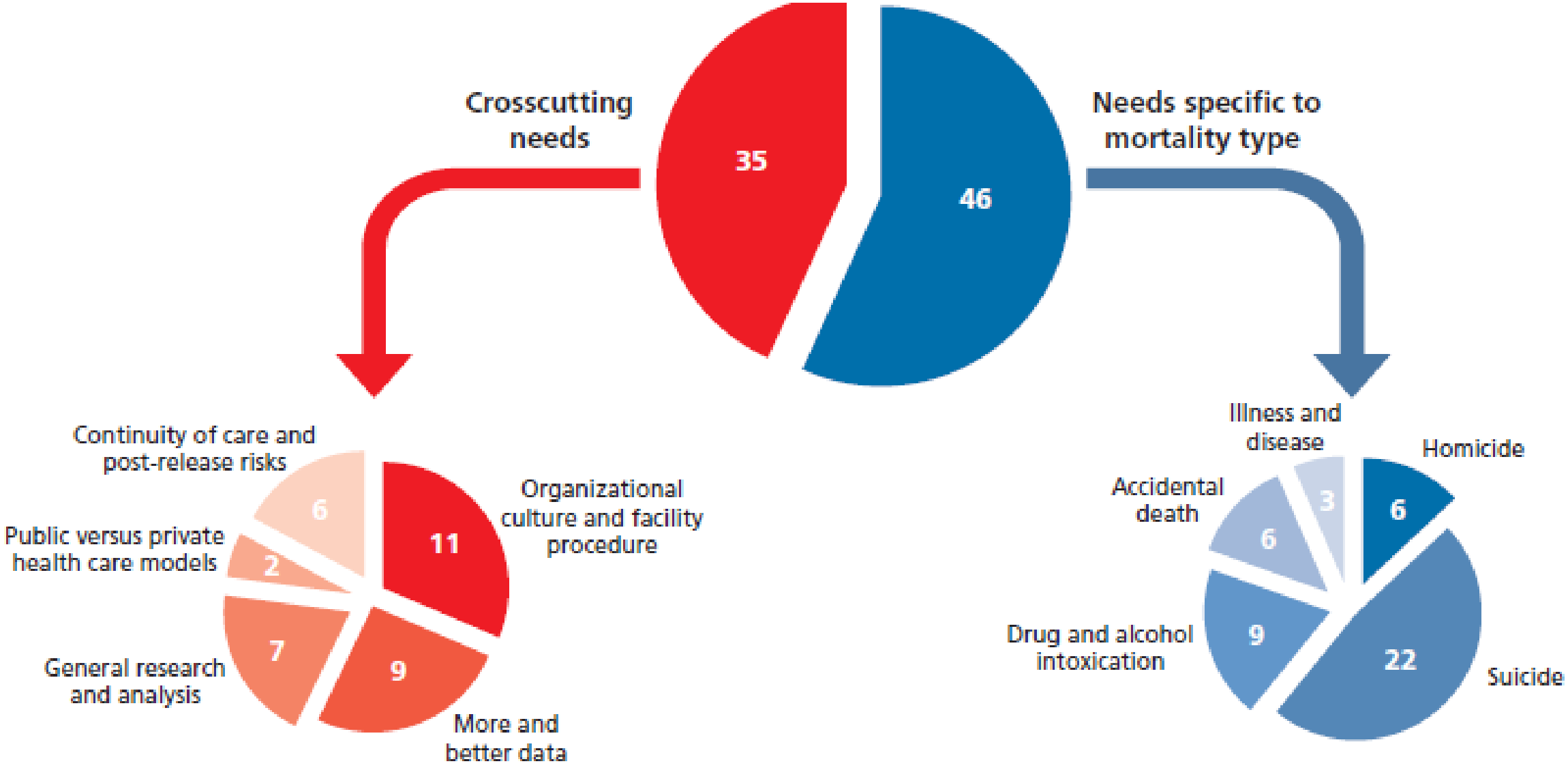


Prisons








Crosscutting needs
35
46
Needs specific to mortality type
Continuity of care and post-release risks
6
Organizational culture and facility procedure
11
Public versus private health care models
2
General research and analysis
7
More and better data
9
Illness and disease
3
Homicide
6
Accidental death
6
Drug and alcohol intoxication
9
Suicide
22

COMMITTEE ON HOMELAND SECURITY

Roger A. Mitchell Jr., M.D.

On the C-SPAN Networks:
Roger A. Mitchell Jr., M.D. is a Chief Medical Examiner for the Washington, D.C. with **two** videos in the C-SPAN Video Library; the first appearance was a 2018 **Forum**. The year with the highest average number of views per program was **2020** with an average of 601 views per program.

Appearances by Title:
Chief Medical Examiner, Washington, D.C.
Videos: 2

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Safety of Children in U.S. Customs and Border Protection Custody

The House Homeland Security Committee held a virtual hearing on the deaths of two migrant children who died while in the custody of U.S....

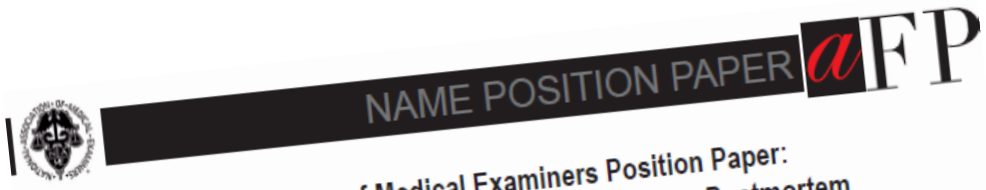
CHILDREN IN CBP CUSTODY: EXAMINING DEATHS, MEDICAL CARE PROCEDURES, AND IMPROPER SPENDING

WRITTEN TESTIMONY

ROGER A. MITCHELL, JR. MD
CHIEF MEDICAL EXAMINER
WASHINGTON DC
JULY 15, 2020


Investigation Into Migrant Child's Death
7-year-old Girl in Border Control Custody

The Medicolegal Death Investigation Community is Critical to understanding the depth and scope of Death in Custody



National Association of Medical Examiners Position Paper: Recommendations for the Definition, Investigation, Postmortem Examination, and Reporting of Deaths in Custody

Roger A. Mitchell Jr., Francisco Diaz, Gary A. Goldfogel, Mark Fajardo, Stephany E. Fiore, Tanisha V. Henson, Michelle A. Jorden, Sean Kelly, Scott Luzi, Megan Quinn, Dwayne A. Wolf

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accountable for all aspects of the work, general administrative support, writing assistance and/or technical editing.

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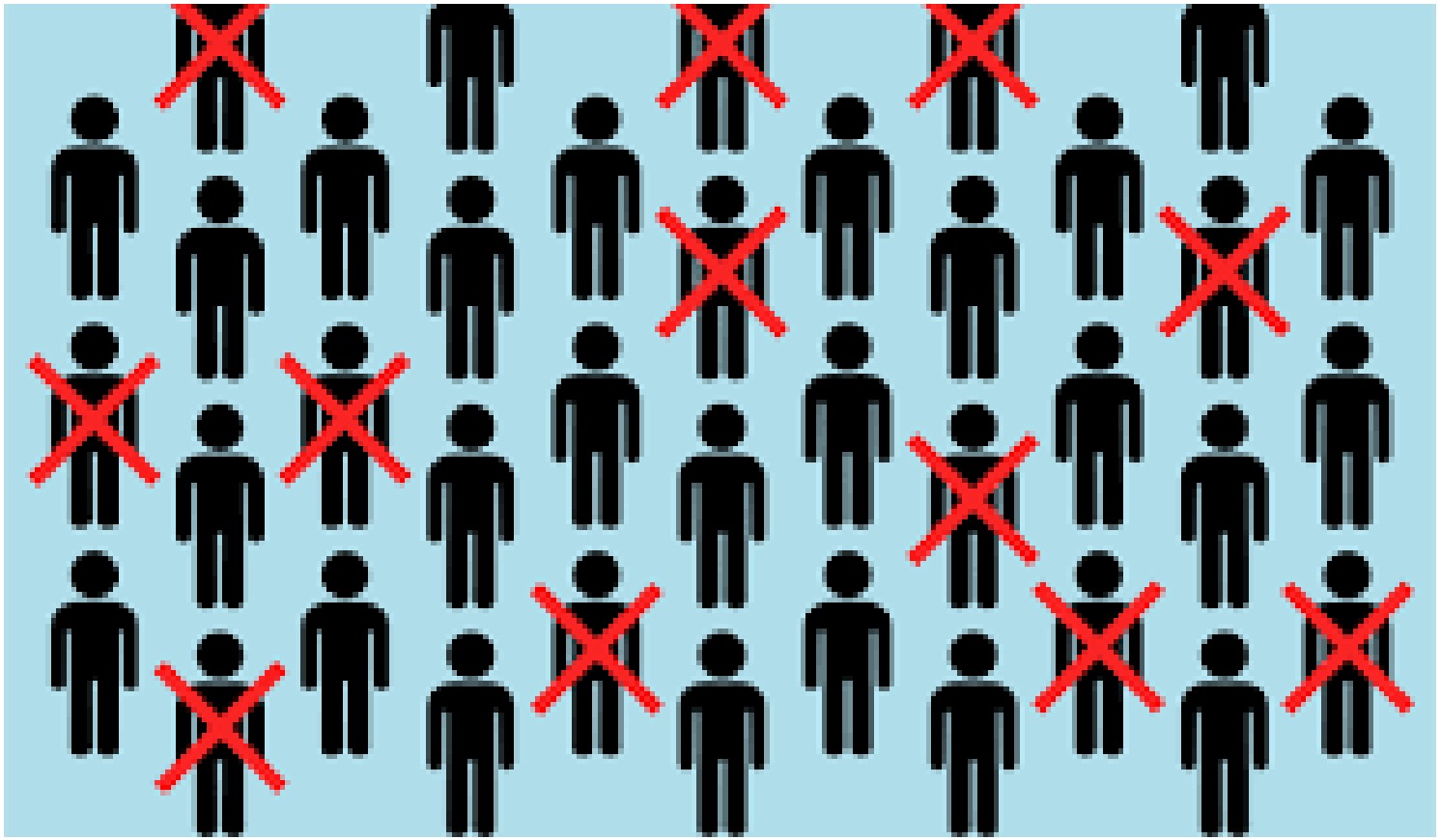


Recommendations for handling Death In Custody

- Investigation
- Autopsy Procedure
  - Photography
  - Radiology
  - Histology
  - Evidence
  - Microbiology
  - Toxicology
  - Ancillary Testing
  - Organ & Tissue
- Death Certification
- Statistical Reporting
- Release on Information

INTERDISCIPLINARY APPROACH

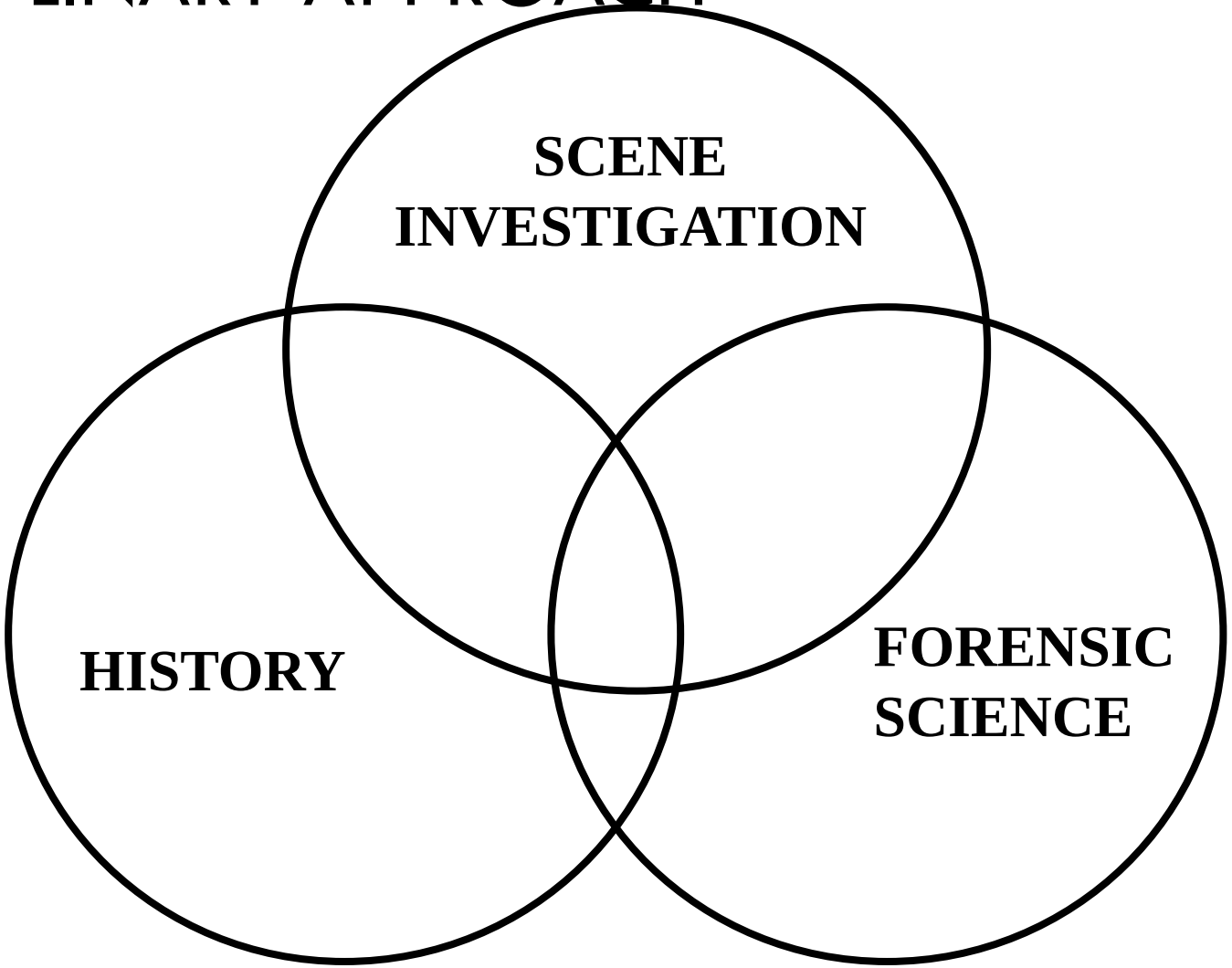
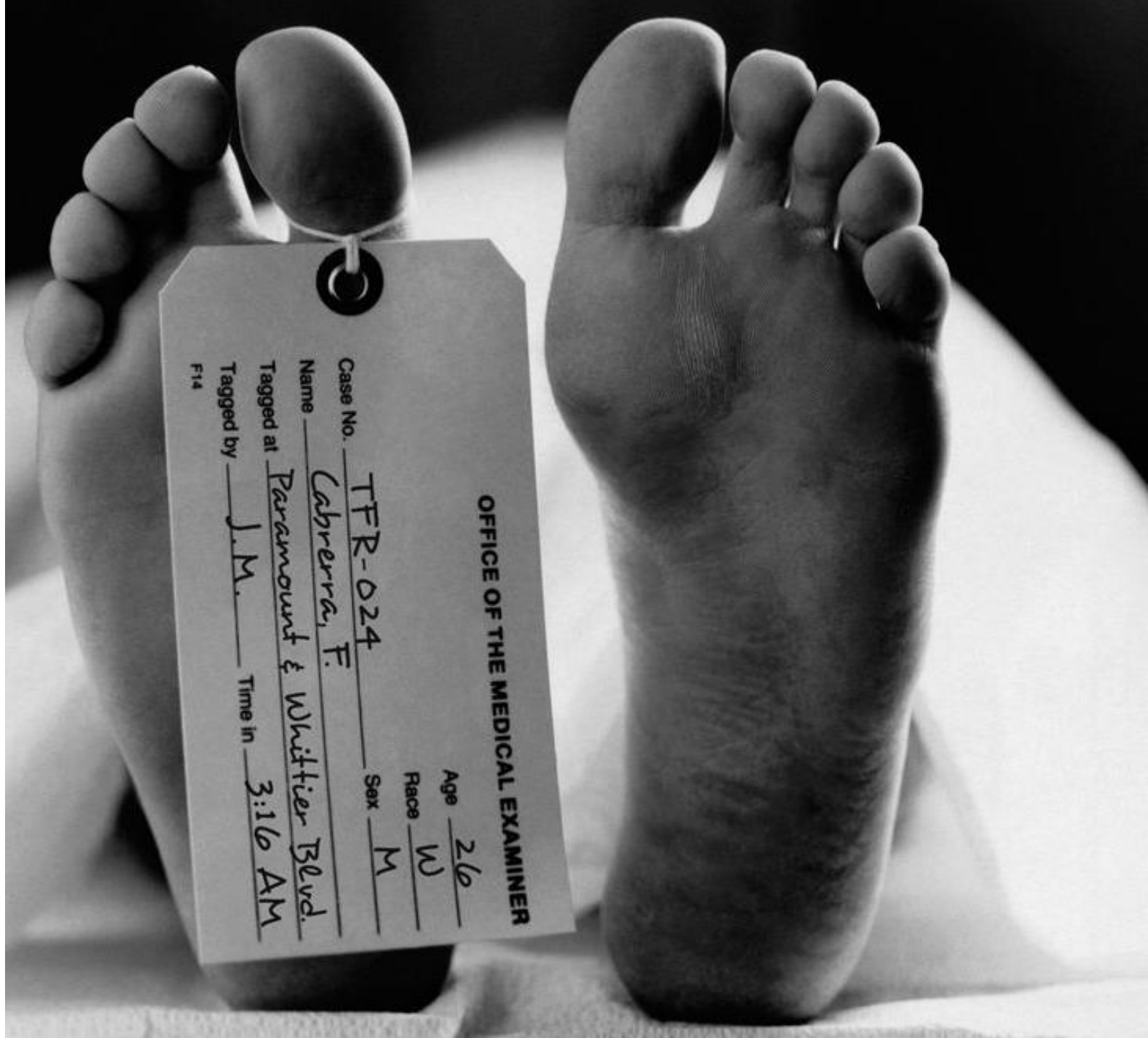


Table 1: List of Recommended Photographs

External Examination	
Total Body	Anterior and posterior views
Face	Close-up (passport style) and bilateral
Eyes	Conjunctivae and sclerae
Mouth	Labial mucosa, frenula, and teeth
Neck	Anterior (extended), posterior, and bilateral views
External genitalia and anus	
Hands and feet	Dorsal, palmar, and plantar views
Wrists, forearms and ankles	Anterior and posterior views
Injuries	
Orientation and close-up views	
Pattern injuries	With American Board of Forensic Odontology-type ruler
Internal Examination	
Reflected scalp	
Calvaria	
Brain (*in situ*)	
Base of skull (dura stripped)	
Chest wall (layered with sternum and ribs visible)	Anterior and bilateral views
Neck (layered)*	Anterior and posterior
Torso (subcutaneous dissection)*	Back and buttocks
Extremities (subcutaneous dissection)*	Including wrists and ankles

Death Certification

- Natural
  - 100% Natural
- Homicide
- Suicide
- Accident
- Undetermined



A Guide For Manner of Death Classification

First Edition

National Association of Medical Examiners ®

Prepared by
Randy Hanzlick, MD
John C. Hunsaker III, MD, JD
Gregory J. Davis, MD

Approved by the NAME Board of Directors
February 2002

Incremental Degrees of Certainty

- Undetermined (less than 50% certainty)
- Reasonable medical or investigative probability (Greater than a 50:50 chance; more likely than not)
- Preponderance of medical/investigative evidence (For practical purposes, let's say about 70% or greater certainty)
- Clear and convincing medical/investigative evidence (For practical purposes, let's say 90% or greater certainty)
- Beyond any reasonable doubt (essentially 100% certainty)
- Beyond any doubt (100% certainty)

General “rules” for classifying Manner of Death

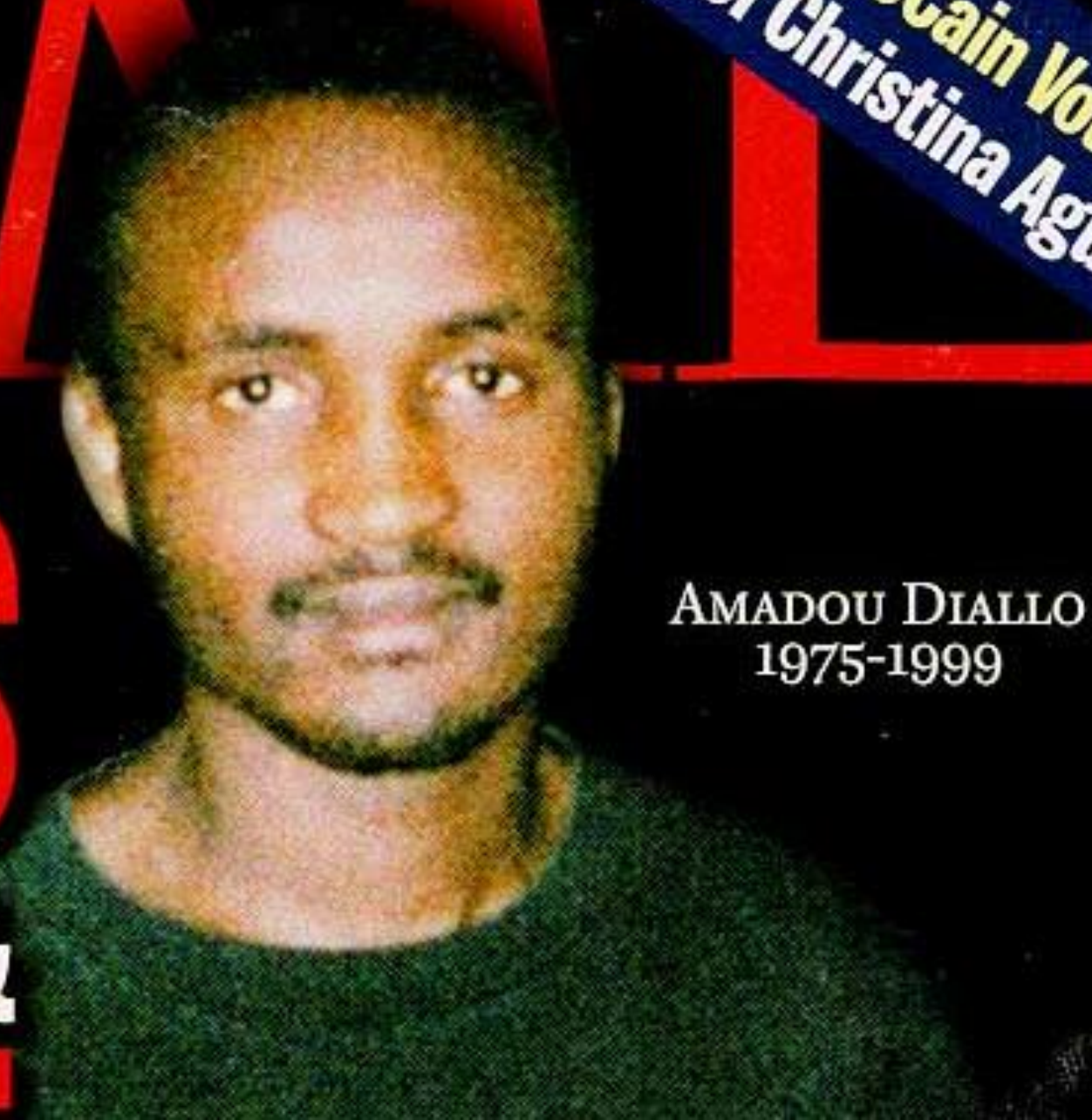
- Natural deaths are due solely or nearly totally to disease and/or the aging process
- Accident applies when an injury or poisoning causes death and there is little or no evidence that the injury or poisoning occurred with intent to harm or cause death. In essence, the fatal outcome was unintentional.
- Suicide results from an injury or poisoning as a result of an intentional, self-inflicted act committed to do self harm or cause the death of one’s self.
- Homicide occurs when death results from a volitional act committed by another person to cause fear, harm, or death. Intent to cause death is a common element but is not required for classification as homicide (more below). It is to be emphasized that the classification of Homicide for the purposes of death certification is a “neutral” term and neither indicates nor implies *criminal* intent, which remains a determination within the province of legal processes.
- Undetermined or “could not be determined” is a classification used when the information pointing to one manner of death is no more compelling than one or more other competing manners of death in thorough consideration of all available information.
- In general, when death involves a combination of natural processes and external factors such as injury or poisoning, preference is given to the non-natural manner of death.

TIME

Is the McCain Voter?

Making of Christina Aguilera

COPS BRUTALITY & RACE



Amadou Diallo
1975-1999

Case Example: Obese man dies in altercation with Bar owner

Brief History

- A 55-year-old man with a history of heart disease, obesity, and diabetes is reported to get into an altercation with three people prior to his death. Witness statements indicate the decedent was drunk and belligerent in a bar when three men fight him to get him to comply with the bar owner until law enforcement arrives. While the three men have him on the ground, he becomes unresponsive. He is dead at the scene.

Case Example: Obese man dies in altercation with Bar owner

Autopsy Findings

- 55 yo, 260 lbs, 71 ½ inches
- Multiple abrasions of the head and face
  - Large brush abrasion on his forehead
- Deep tissue hemorrhages of the forearms
- Focal abrasions of the torso
  - Deep tissue hemorrhages of the upper back and shoulders
- Posterior pharyngeal soft-tissue hemorrhage
  - Focal Petechia
- No Fractures
- Heart – 500 grams (50% stenosis of the LAD), Myocyte hypertrophy
- Toxicology – Ethanol at 1.2 mg/dL

What is the Cause and Manner of Death?

Case Example: Severely Autistic Man in altercation with law enforcement

Brief History

- 45 yo autistic man who wandered away from his group while at a park. Law enforcement was called to find him. When encountered he did not respond to the commands of law enforcement. He was forcibly taken to the ground, restrained, and handcuffed. He became unresponsive within minutes of the altercation and was unresponsive. He was taken to the hospital where he was pronounced dead.

Case Example: Severely Autistic Man in altercation with law enforcement

Autopsy Findings

- 45 yo, 220 lbs, 69 ½ inches
- Multiple abrasions of the head and face
  - Large brush abrasion of the left side of his face
- Tram-Track abrasions of the wrists consistent with handcuffs
  - Deep tissue hemorrhages of the forearms
- Focal abrasions of the torso
  - Deep tissue hemorrhages of the upper back and shoulders
- Posterior pharyngeal soft-tissue hemorrhage
  - Focal Petechia
- No Fractures
- Heart – 400 grams (30% stenosis of the LAD), Myocyte hypertrophy
- Toxicology - Negative

What is the Cause and Manner of Death?

There is a culture and philosophy within Medicolegal Death Investigation Systems that certifies manner of death as Accident or Undetermined when an altercation with law enforcement results in death.


UNIFORMITY


peer review
assessment
performance
inspect
supervisor
analysis
assess
process
scrutiny
examine
evaluate
study
worker
talking
boss
peers
information
teamwork
company
coworkers
feedback
reviewing
discussing
performer
business
reviewed
time
notebook
perform
look
working
partner
system
job
report
inspection
computer
evaluating
employer
american
survey
people
looking
career
inspecting
businesswoman
businessman
colleagues
positive
person
analyze
conversation
evaluation
management
team
employee
corporate
appraisal
resources
coworker

Reliability and Reproducibility

Social Science & Medicine 70 (2010) 209–216

Contents lists available at ScienceDirect

Social Science & Medicine

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Do guidelines create uniformity in medical practice?

Judith D. de Jong [a,*], Peter P. Groenewegen [a,b], Peter Spreeuwenberg [a], François Schellevis [a,c], Gert P. Westert [d,e]

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ARTICLE INFO

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Available online 29 October 2009

Keywords:
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Guidelines
Medical practice
The Netherlands
Drug prescriptions

ABSTRACT

This article aimed to test the general hypothesis that guidelines create uniformity, or reduce variation, in medical practice. Medical practice variation has policy interest and is one of the reasons for developing guidelines. The development and implementation of guidelines was considered in the broader context of processes of rationalization. We focused on the influence of voluntary guidelines developed by the professional organization for family physicians in the Netherlands on variation in drug prescription.

Data were used from the First and Second Dutch National Survey of General Practice (DNSGP1 and DNSGP2), collected in 1987 and 2001 respectively. DNSGP1 consisted of 103 practices and 161 GPs serving 335.000 patients. DNSGP2 consisted of 104 practices and 195 GPs serving 390.000 patients. Two groups of diagnoses were created, one containing all diagnoses for which guidelines were introduced and one containing all other diagnoses. For both groups a measure of concentration, Herfindahl-Hirschman Index (HHI), was used to represent variation. This measure of concentration was compared between both groups using multilevel analysis.

Results showed that although there was an overall increase in variation (a significantly lower HHI) in prescription, the increase was less in the cases of diagnoses for which guidelines were introduced. Guidelines, primarily, had an effect on variations in single-handed practices. The overall conclusion is that the introduction of guidelines, although it probably tempered the increase in variation, did not reduce variation.

Introduction

In the classical conception of medicine as a profession, medical practice is largely uniform through the shared body of (theoretical) knowledge. Variation originates from the necessity to apply this theoretical knowledge to individual patients. However, when clinical variables and patient characteristics are taken into account, there is variation left. Whatever the origin of this part of variation, it is striking that this variation has been found to show clear patterns by country, region, hospital and practice. Explanations for variation are sought in differences in opinions or enthusiasm for certain procedures between individual physicians, and in differences in constraints and social influences for groups of physicians (Chassin, 1993; de Jong, 2008; Landon, Reschovsky, Reed, & Blumenthal, 2001; Wennberg & Gittelsohn, 1975; Westert & Groenewegen, 1999). Variation in medical practice is not a bad thing by definition; without variation there probably will be no progress. However, it is the downside of variation that attracts attention from third parties. Evidence of variations in medical practice suggests the possibility of inappropriate servicing, wasting of resources and even actual harm to patients (Evans, 1990). The existence of variation has policy interest and is one of the reasons, besides rising health care costs, for developing guidelines. The use of clinical guidelines that give recommendations about appropriate health care is a way of reducing variation and maintaining, or improving, the quality of health care (Grilli, Magrini, Penna, Mura, & Liberati, 2000; Hutchinson, McIntosh, Cox, & Gilbert, 2003; Langley, Faulkner, Ch. Watkins, Gray, & Harvey, 1998; Lomas et al., 1989). A wide variety of guidelines has been developed in the last decades for hospitals and physicians (Grimshaw et al., 2004; Hibble, Kanka, Pencheon, & Pooles, 1998). In this article guidelines for family physicians in the Netherlands will be studied.

In The Netherlands guidelines are developed for family physicians by the Dutch College of General Practitioners. The first appeared in 1989 and over 80 guidelines for different diagnoses

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doi:10.1016/j.socscimed.2009.10.016

Cases may require interdisciplinary consultation and review.

The New York Times

@nytimes

20 minutes ago

NYT Investigation: How a genetic trait in Black people can give the police cover

Sickle cell trait has been cited in dozens of police custody deaths ruled accidental or natural, even though the condition is benign on its own, a New York Times investigation found.

https://www.nytimes.com/2021/05/15/us/african-americans-sickle-cell-police.html

The New York Times

2006.

"You can't put the blame on sickle cell trait when there is a knee on the neck or when there is a chokehold or the person is hogtied," said Dr. Roger A. Mitchell Jr., the former chief medical examiner for the District of Columbia and now chairman of pathology at the Howard University College of Medicine. "You can't say, 'Well, he's fragile.' No, that becomes a homicide."

Not every death that is tied to the condition is inherently questionable. Medical experts say sickle cell trait has caused deaths in rare cases of extreme overexertion, especially among military trainees and college athletes. Three of the in-custody deaths identified by The Times involved people who were exercising vigorously in jail yards or running hard before they collapsed — and law enforcement officers said that at most they put handcuffs on them.

SCIENTIFIC AMERICAN®

POLICY & ETHICS | OPINION

Some Medical Examiners Say Sickle Cell Trait Causes Sudden Death—They're Wrong

The genetic factor that contributed most to the deaths of 47 Black men in police custody was the color of their skin, not the contents of their red blood cells

By A. Kyle Mack, Rachel S. Bercovitz, Hannah Lust on June 20, 2021

ASH Clinical News®

Sickle Cell Trait Cited in Police Custody Deaths

THURSDAY, JULY 1, 2021

In a review of data on suspicious deaths from more than 30 of the largest U.S. counties, *The New York Times* found that sickle cell trait (SCT) was cited as a cause or factor in 47 deaths

ASH Position on Sickle Cell Trait

PUBLISHED ON:
MAY 25 2021

ASH Position

It is medically inaccurate to claim sickle cell crisis as the cause of death based solely on the presence of sickled cells at autopsy. Sudden death is an extraordinarily rare occurrence in sickle cell trait and the finding of sickle cell trait is unlikely to supersede other inflicted traumas as the cause or major factor in death. Millions of American men, women and children with sickle cell trait lead normal, healthy lives, and there have been no well-controlled studies on collapse due to exertion that would provide evidence to cite sickle cell trait as a cause of death. Because of the rarity of sudden death in persons with sickle cell trait, cases where this is cited as the sole cause of death, or a major contributor must be viewed with profound skepticism.

Background

The American Society of Hematology (ASH) represents approximately 18,000 physicians, scientists, and medical trainees committed to the study and treatment of blood and blood-related diseases. ASH members include clinicians who specialize in treating children and adults with sickle cell disease (SCD) and researchers who investigate the causes and potential treatments of SCD manifestations.

Sickle cell disease is an inherited blood disorder that affects 80,000 to 100,000 Americans, mostly but not exclusively of African ancestry. Sickle cell disease requires inheritance of two variants of the *HBB* gene which results in production of abnormal hemoglobin. The sickle variant of hemoglobin causes severe anemia, pain, other devastating disabilities, and, in some cases, premature death.

Conduct Peer Review Interdisciplinary Consultation

- Internal daily review of cases
- Review amended cases from “Pending” to final COD/MOD
- Review all Homicides and Undetermined Cases
- Review all Death in Custody
  - Low threshold for interdisciplinary consultation (Pulmonology, Cardiology, Hematology, etc.)
  - Low threshold for pathology consultation (Neuropathology, Cardiac Pathology)

The People's Organization for Progress led a march through Orange Friday to commemorate the National Day Against Police Brutality. After the march from City Hall to police headquarters, marchers conducted an all-night candlelight vigil at headquarters.

March, vigil raise awareness about police brutality, Faison

By Mark Goldwert
Staff Writer

Like dozens of other cities around the country, Orange was the scene of a demonstration Friday to commemorate the National Day Against Police Brutality. The event in Orange saw concerned activists and Orange residents take to the streets for a march and candlelight vigil in memory of those who have suffered abuse, torture and death at the hands of law enforcement members.

In the case of Orange, the event was fueled by the still burning controversy surrounding the death of 22-year-old Earl Faison while in the custody of the Orange police.

Arrested in April as a suspect in the shooting death of Orange Police Officer Joyce Carnegie, Faison allegedly was handcuffed, robbed, beaten and pepper-sprayed in the nose and mouth before dying just minutes later, according to the grand jury testi- [illegible] police officer on duty the

by the director to the contrary.

Conte, however, claims the federal investigation into his department is not the motive for resigning.

"We totally disagree," said Hamm, responding to Conte's statement. "You would have to be naive to think the FBI investigation had nothing to do with it."

"I think the police director is trying to run away from the situation," said Faison's uncle, James.

Although the march and vigil went mostly unacknowledged by local leaders, North Ward Councilman Donald Page made a brief appearence outside city hall with Hamm and members of Faison's family, and addressed the crowd in front of police headquarters.

"I'm here to support the Faison family, not to bash the Orange Police Department," said Page, speaking to the crowd through a megaphone. "We have good cops, cops that I'm proud of, but we do have police brutality. It does exist."

[illegible] why he did not

Orange police officers arrived on the scene just after the march turned onto Lincoln Avenue. They spoke with Hamm and POP attorney Anthony Mack as the demonstrators continued on their way. Later, in front of police headquarters, Hamm described the encounter with police.

"They said we didn't have a permit," Hamm told the crowd using his megaphone. "But without fail we have always contacted the police. Anthony Mack contacted the police and their response was 'Do whatever you want. We don't care.' "

The result of the confrontation was a police escort for the remainder of the march.

The sidewalk along the remainder of the route was dotted with onlookers, some of whom simply stared, others who watched with their fists raised in support or joined in the chanting.

On Lincoln Avenue, residents looked out from apartment windows as the marchers' cries rang out: "What do we want?" "Justice." "When do we [illegible] victims

BJA

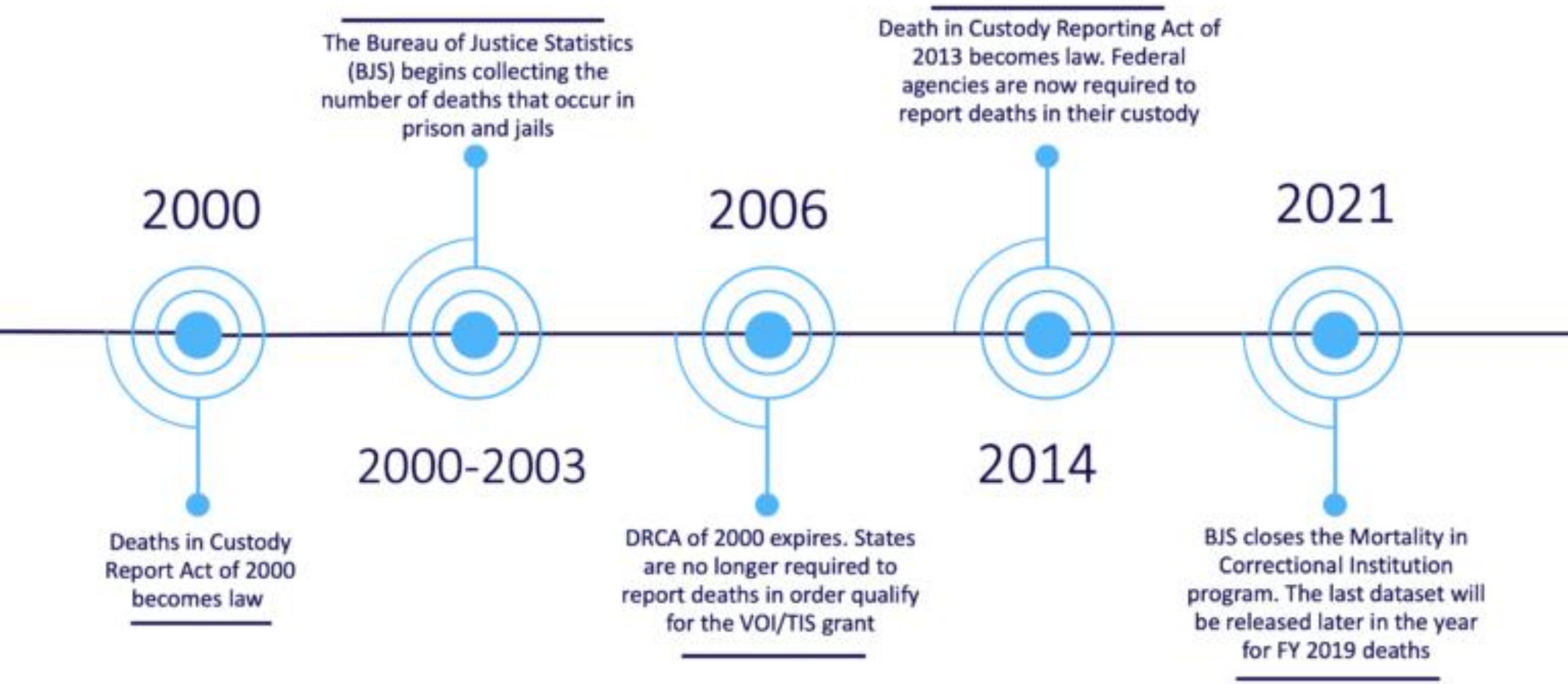
Bureau of Justice Assistance
U.S. Department of Justice

DEATH IN CUSTODY REPORTING ACT

REPORTING GUIDANCE AND FREQUENTLY ASKED QUESTIONS

Version 3.0; revised March 2022

DEATH IN CUSTODY REPORTING



JULY 07, 2020

Senators Request Full Implementation, Enforcement of the Death In Custody Reporting Act

Washington–Senator Dianne Feinstein (D-Calif.) joined Senator Richard Blumenthal (D-Conn.) and a group of their colleagues to write to Attorney General William Barr calling for the immediate, full implementation and enforcement of the *Death in Custody Reporting Act*.

"One stark, staggering fact is that there exists no reliable metric on the number of law enforcement-related deaths that occur each year because DOJ has failed to implement and enforce the DCRA," the senators wrote. "To be clear, the DCRA will not alone solve the underlying problem. We acknowledge that the data collected pursuant to the DCRA is neither the justice, nor the accountability that the problem demands, but it is a critical step in that direction. That data can—and will—inform the substantive and structural reforms that we must make in the weeks and months ahead. To that end, we demand that you begin the immediate implementation and enforcement of the DCRA."

In addition to Feinstein and Blumenthal, the letter was also signed by Senators Chuck Schumer (D-N.Y.), Kamala D. Harris (D-Calif.), Cory A. Booker (D-N.J.), Bernie Sanders (I-Vt.), Sheldon Whitehouse (D-R.I.), Edward J. Markey (D-Mass.), Kirsten Gillibrand (D-N.Y.), Chris Van Hollen (D-Md.), Patrick Leahy (D-Vt.), Tammy Baldwin (D-Wis.), Dick Durbin (D-Ill.), Ron Wyden (D-Ore.), Sherrod Brown (D-Ohio), Mazie K. Hirono (D-Hawaii) and Amy Klobuchar (D-Minn.).

The full text of the senators' letter is below.

Dear Attorney General Barr:

We write to request that the Department of Justice ("DOJ") take immediate action to implement and enforce the Death in Custody Reporting Act of 2013 ("DCRA").[1] It has been six years since Congress passed, with bipartisan support, the DCRA and, in those six years, DOJ has not taken meaningful steps toward full implementation or enforcement.[2] That is simply unacceptable.

SCOTT PRESSES ATTORNEY GENERAL BARR TO ENFORCE LAW TO RECORD DEATHS IN POLICE CUSTODY

June 9, 2020 | Press Release

Letter comes amidst national outcry for policing reform after the murder of George Floyd

WASHINGTON, D.C. – Congressman Bobby Scott (VA-03) sent a letter to U.S. Attorney General William Barr demanding the Justice Department to enforce the *Death in Custody Reporting Act of 2013 (DCRA)*. The DCRA requires states receiving federal criminal justice grants to report the death of any individual detained, arrested, in transit to incarceration, or incarcerated in state or local facilities. Congressman Scott sponsored the Death in Custody Reporting Act in 2000 and it became law with bipartisan support. In 2014 the law was reauthorized by Congress.

"As our nation continues to mourn and protest the senseless and avoidable death of George Floyd at the hands of law enforcement, I respectfully request that the Department of Justice take immediate action to implement and enforce the Death in Custody Reporting Act (DCRA) of 2013," **the Congressman wrote.** *"The Department has been derelict in its duty to collect accurate information about police misconduct and the conditions of incarceration in this country."*

For years the Department of Justice (DOJ) has delayed full implementation and enforcement of DCRA. The Department's Inspector General issued a report on the DOJ's failure to implement the law and provided recommendations to ensure compliance.

"In December 2018, the Department's Inspector General issued a report on the Department's failure to implement the law and provided recommendations to ensure compliance," **the Congressman continued.** *"Over the next year, the Department made little to no progress in implementing many of the Inspector General's recommendations. Earlier this year, House Judiciary Committee Chairman Jerry Nadler and Crime Subcommittee Chair Karen Bass called for an investigation into the Department's failure to collect DCRA data and to implement the IG's recommendations.*

In the six years since the law was reauthorized, the Department of Justice has yet to properly implement the law.

"Men and women continue to die at the hands of law enforcement," **the Congressman stated.** *"Policymakers do not have access to government data on the nature and circumstances of these deaths. Instead the public and lawmakers must rely solely on the work of non-profit organizations and the media. Despite the tremendous work of investigative journalists and these non-profit organizations in cataloging deaths in custody, there is still an incomplete picture of the problem. The Department cannot abdicate its duty to the public in this matter any longer."*

Media

In the News
Press Releases
Floor Statements
Feeds
Facebook
Twitter
YouTube
Instagram
Flickr

U.S.

The New York Times

UPGRADE NOW

Account

U.S. | More Than Half of Police Killings Are Mislabeled, New Study Says

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nformation from death
at track police killings
discrepancy.

178

paramedics injected him with ketamine, a powerful sedative. Almost two years later, three officers and two paramedics were indicted.

Even in the case of George Floyd, whose agonizing last breaths under a Minneapolis police officer's knee were captured on bystander video, the police and the county medical examiner first pointed to drug use and underlying health conditions.

The National Association of Medical Examiners encourages the classification of deaths caused by law enforcement as homicides, in part to reduce the appearance of a cover-up (a homicide may still be deemed justified). But classification guidelines differ from office to office, and there are no national standards.

Roger Mitchell Jr., a former chief medical examiner of Washington, D.C., and an expert on investigating deaths in custody, has long said that death certificates should include a checkbox indicating whether a death occurred in custody, including arrest-related deaths as well as those in jails and prisons.

As long as medical examiners are not specifically asked to include that information, he said, he would not jump to conclusions about why they do not do so: "If it's a function of training, a function of bias, a function of institutional and structural racism — all the things we can assume — we can identify that once we have a uniform system."

Articles

Fatal police violence by race and state in the USA, 1980–2019: a network meta-regression

GBD 2019 Police Violence US Subnational Collaborators*

Summary

Background The burden of fatal police violence is an urgent public health crisis in the USA. Mounting evidence shows that deaths at the hands of the police disproportionately impact people of certain races and ethnicities, pointing to systemic racism in policing. Recent high-profile killings by police in the USA have prompted calls for more extensive and public data reporting on police violence. This study examines the presence and extent of under-reporting of police violence in US Government-run vital registration data, offers a method for correcting under-reporting in these datasets, and presents revised estimates of deaths due to police violence in the USA.

Methods We compared data from the USA National Vital Statistics System (NVSS) to three non-governmental, open-source databases on police violence: Fatal Encounters, Mapping Police Violence, and The Counted. We extracted and standardised the age, sex, US state of death registration, year of death, and race and ethnicity (non-Hispanic White, non-Hispanic Black, non-Hispanic of other races, and Hispanic of any race) of each decedent for all data sources and used a network meta-regression to quantify the rate of under-reporting within the NVSS. Using these rates to inform correction factors, we provide adjusted estimates of deaths due to police violence for all states, ages, sexes, and racial and ethnic groups from 1980 to 2019 across the USA.

Findings Across all races and states in the USA, we estimate 30 800 deaths (95% uncertainty interval [UI] 30 300–31 300) from police violence between 1980 and 2018; this represents 17 100 more deaths (16 600–17 600) than reported by the NVSS. Over this time period, the age-standardised mortality rate due to police violence was highest in non-Hispanic Black people (0·69 [95% UI 0·67–0·71] per 100 000), followed by Hispanic people of any race (0·35 [0·34–0·36]), non-Hispanic White people (0·20 [0·19–0·20]), and non-Hispanic people of other races (0·15 [0·14–0·16]). This variation is further affected by the decedent's sex and shows large discrepancies between states. Between 1980 and 2018, the NVSS did not report 55·5% (54·8–56·2) of all deaths attributable to police violence. When aggregating all races, the age-standardised mortality rate due to police violence was 0·25 (0·24–0·26) per 100 000 in the 1980s and 0·34 (0·34–0·35) per 100 000 in the 2010s, an increase of 38·4% (32·4–45·1) over the period of study.

Interpretation We found that more than half of all deaths due to police violence that we estimated in the USA from 1980 to 2018 were unreported in the NVSS. Compounding this, we found substantial differences in the age-standardised mortality rate due to police violence over time and by racial and ethnic groups within the USA. Proven public health intervention strategies are needed to address these systematic biases. State-level estimates allow for appropriate targeting of these strategies to address police violence and improve its reporting.

Funding Bill & Melinda Gates Foundation, National Institute on Minority Health and Health Disparities, and National Heart, Lung, and Blood Institute.

Lancet 2021; 398: 1239–55

See Editorial page 1195

*Collaborators listed at the end of the paper

Correspondence to: Prof Mohsen Naghavi, Department of Health Metrics Sciences, Institute for Health Metrics and Evaluation, School of Medicine, University of Washington, Seattle, WA 98105, USA

naghavi@uw.edu

Introduction

The Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) in 2019 found that police conflict and executions accounted for 293 000 global deaths (95% uncertainty interval [UI] 215 000–344 000) from 1980 to 2019.[1] In 2019, the USA accounted for 13·2% (95% UI 11·6–15·1) of the 8770 global deaths (7710–9930) due to police conflict while only accounting for 4% of the global population;[2] police conflict and executions was the estimated cause of death for 1150 deaths (998–1310) in the USA.[1] The burden of police violence fatalities in the USA is known to fall disproportionately on Black, Indigenous, and Hispanic populations.[2–5] Recent studies suggest that over the life course, about one in every 1000 Black men are killed by the police in the USA, making them 2·5 times more likely to be killed by police than White men.[2] Black women are about 1·4 times more likely to be killed by police than are White women.[2] Systemic and direct racism, manifested in laws and policies as well as personal implicit biases, result in Black, Indigenous, and Hispanic Americans being the targets of police violence.[6–9]

Within GBD, deaths due to police conflict and executions include civilians killed by police, police killed by civilians, and government-led executions.[1] Police violence is defined in GBD as police-related altercations leading to death or bodily harm. For the purpose of this study, we estimate numbers of civilians killed by police

Centers for Disease Control and Prevention
National Center for Health Statistics

Tracking Death in Custody is the responsibility of the Centers for Disease Control as well as the Department of Justice

Include a **Checkbox** on the US Standard Death Certificate

Established along lines of Phases

Pre-Custody, In-Custody, Incarcerated

Reliable and Reproducible Data

National Uniformity of Certification

Develop Continuing Education Module

Support Multidisciplinary Research and Advocacy

NMA Since 1895 ®

National Medical Association

CAUSE OF DEATH

Part I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
A.
Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last.
B.
Due to (or as a consequence of)

C.
Due to (or as a consequence of)

D.
Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

(max 240 characters)

Manner of Death

Was an Autopsy Performed? Yes No Unknown

Were the Results of the Autopsy Available to Complete the Cause of Death? Yes No Unknown

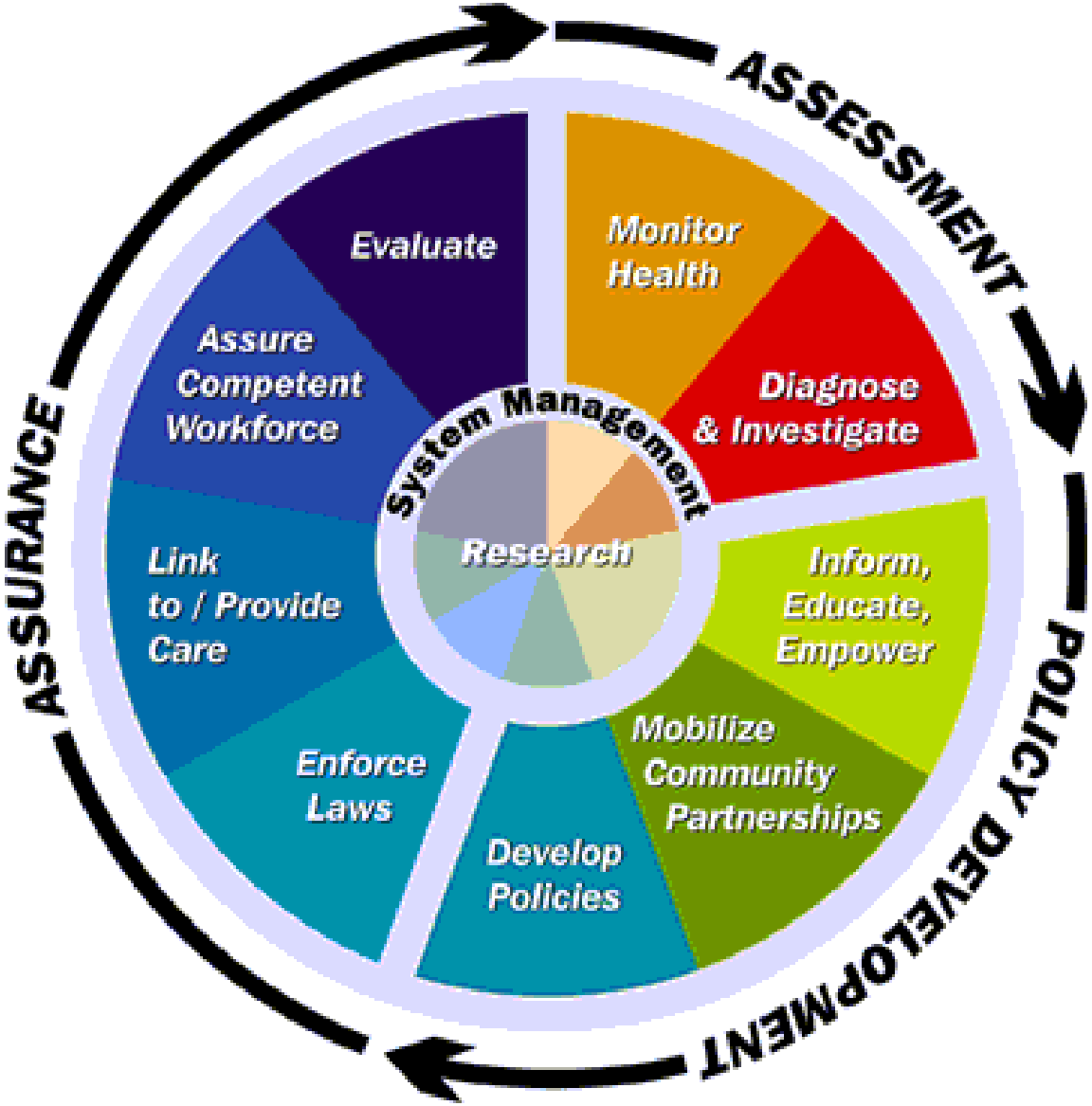
Death in Custody Yes No Unknown

Manner of Death

Did Tobacco Use Contribute to Death?

OFFICE OF THE CHIEF MEDICAL EXAMINER
DISTRICT of COLUMBIA
CHIEF MEDICAL EXAMINER

DEFINING DEATH ACCORDING TO PHASE ALLOWS FOR PUBLIC HEALTH REPORTING AND DATA COLLECTION ACROSS ALL MANNERS OF DEATH.

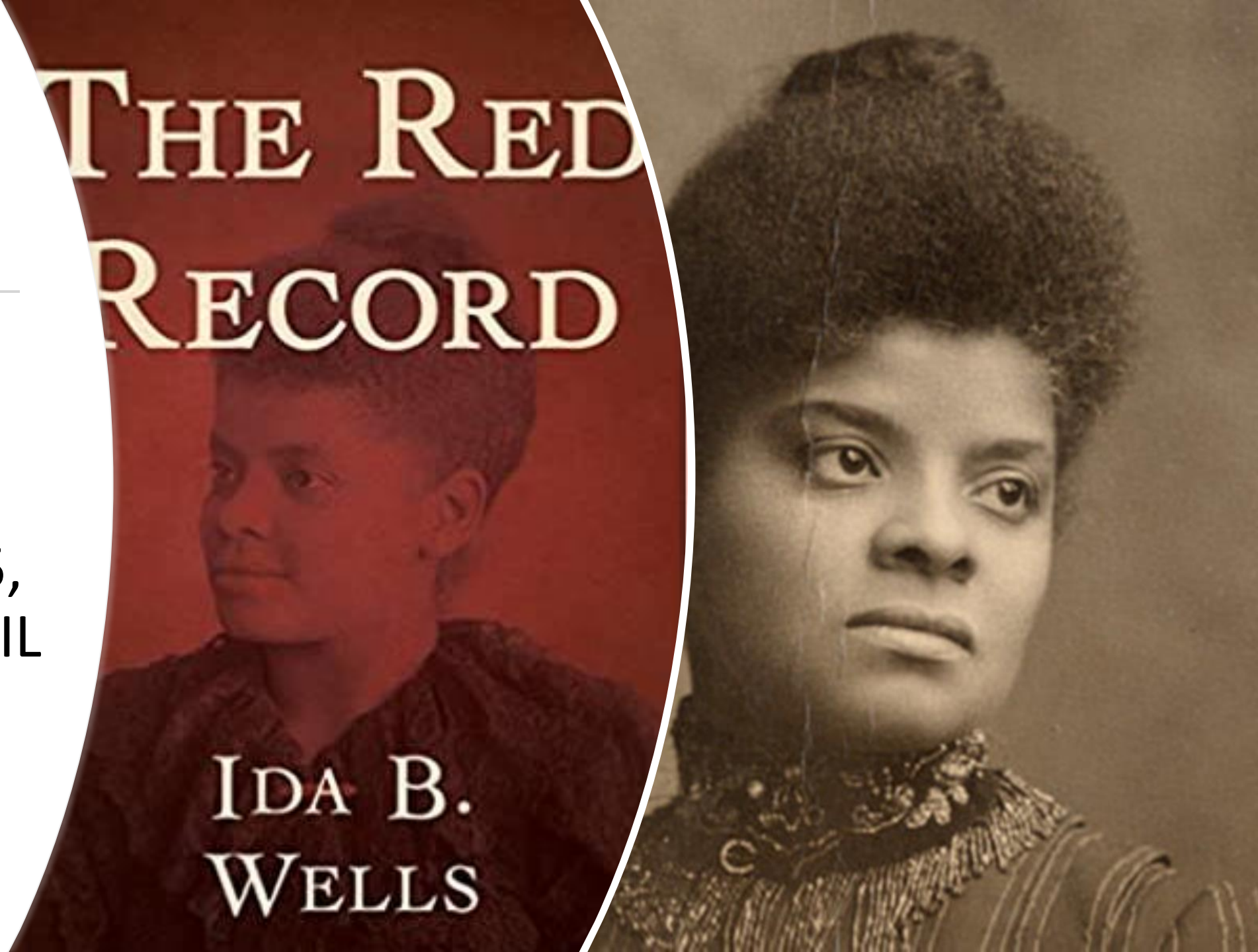


There is a Sorted History between the Medicolegal Death Investigation System and the Extrajudicial killing of Americans

IDA B. WELLS

Born: July 16, 1862, Holly Springs, MS

Died: March 25, 1931, Chicago, IL



THE SHAME OF AMERICA

Do you know that the United States is the Only Land on Earth where human beings are BURNED AT THE STAKE?

In Four Years, 1918-1921, Twenty-Eight People Were Publicly BURNED BY AMERICAN MOBS

3436 People Lynched 1889 to 1922

For What Crimes Have Mobs Nullified Government and Inflicted the Death Penalty?

The Alleged Crimes	The Victims
Murder	1288
Rape	871
Crimes against the Person	615
Crimes against Property	333
Miscellaneous Crimes	453
Absence of Crime	176
	3436

Why Some Mob Victims Died:

Not turning out of road for white boy in auto
Being a relative of a person who was lynched
Jumping a labor contract
Being a member of the Non-Partisan League
"Talking back" to a white man
"Insulting" white man.

Is Rape the "Cause" of Lynching?

Of 3,436 people murdered by mobs in our country, only 571, or less than 17 per cent., were even accused of the crime of rape.

83 WOMEN HAVE BEEN LYNCHED IN THE UNITED STATES

Do lynchers maintain that they were lynched for "the usual crime"?

AND THE LYNCHERS GO UNPUNISHED

THE REMEDY

The Dyer Anti-Lynching Bill Is Now Before the United States Senate

The Dyer Anti-Lynching Bill was passed on January 26, 1922, by a vote of 230 to 119 in the House of Representatives

The Dyer Anti-Lynching Bill Provides:
That culpable State officers and mobbists shall be tried in Federal Courts on failure of State courts to act, and that a county in which a lynching occurs shall be fined $10,000, recoverable in a Federal Court.

The Principal Question Raised Against the Bill is upon the Ground of Constitutionality.

The *Constitutionality* of the Dyer Bill Has Been Affirmed by—
The Judiciary Committee of the House of Representatives
The Judiciary Committee of the Senate
The United States Attorney General, legal adviser of Congress
Judge Guy D. Goff, of the Department of Justice

The Senate has been petitioned to pass the Dyer Bill by—
29 Lawyers and Jurists, including two former Attorneys General of the United States
19 State Supreme Court Justices
24 State Governors
2 Archbishops, 85 bishops and prominent churchmen
39 Mayors of large cities, north and south.

The American Bar Association at its meeting in San Francisco, August 9, 1922, adopted a resolution asking for further legislation by Congress to punish and prevent lynching and mob violence.

Fifteen State Conventions of 1922 (3 of them Democratic) have inserted in their party platforms a demand for national action to stamp out lynchings.

The Dyer Anti-Lynching Bill is not intended to protect the guilty, but to assure to every person accused of crime trial by due process of law.

THE DYER ANTI-LYNCHING BILL IS NOW BEFORE THE SENATE
TELEGRAPH YOUR SENATORS TODAY YOU WANT IT ENACTED

If you want to help the organization which has brought to light the facts about lynching, the organization which is fighting for 100 per cent. Americanism, not for some of the people some of the time, but for all of the people, white or black, all of the time

Send your check to J. E. SPINGARN, Treasurer of the

NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE
70 FIFTH AVENUE, NEW YORK CITY

THIS ADVERTISEMENT IS PAID FOR IN PART BY THE ANTI-LYNCHING CRUSADERS.


A MAN WAS
LYNCHED
YESTERDAY
GLOBE-BRENNER

DEATH AT THE HANDS OF UKNOWN PERSONS

Moore's Ford Lynching – Known as the last mass lynching in the US
July 25, 1946

George W. Dorsey and Mae (Murray) Dorsey
Roger Malcom and Dorothy (Dorsey) Malcom (who was seven months pregnant)

SOCIUS

Original Article

Exculpating Injustice: Coroner Constructions of White Innocence in the Postbellum South

Sarah Gaby[1], David Cunningham[2], Hedwig Lee[2], Geoff Ward[2], and Ashley N. Jackson[2]

ASA American Sociological Association

Socius: Sociological Research for a Dynamic World
Volume 7: 1–13

DOI: 10.1177/2378023120983647
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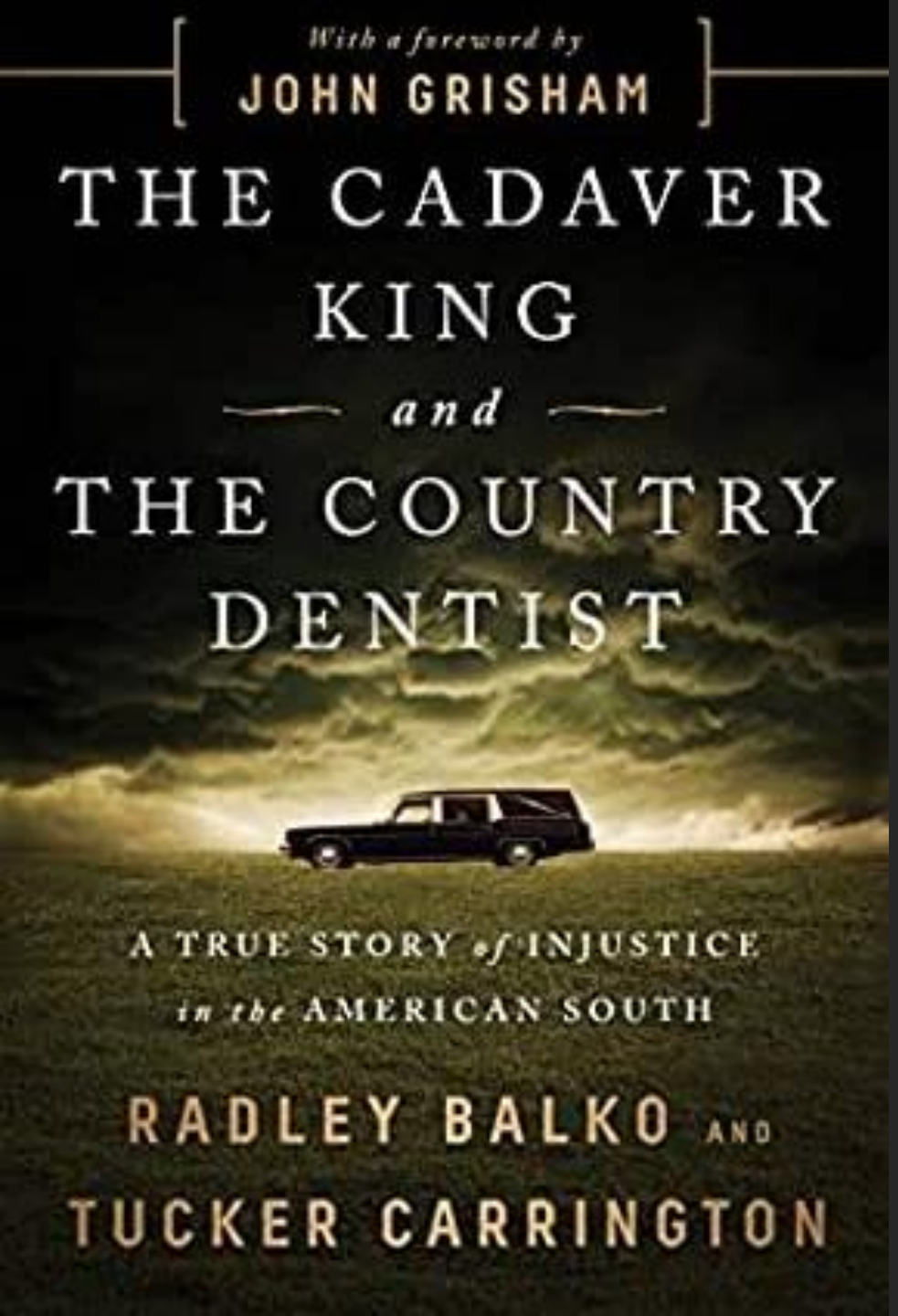


Chapter 4: At the Hands of Unknown Persons

STRENGTHENING FORENSIC SCIENCE IN THE UNITED STATES

A PATH FORWARD

THE CALIFORNIA REPORT

San Joaquin County Should Install Independent Medical Examiner, Audit Finds

By Julie Small Apr 19, 2018 Save Article

FACT SHEET

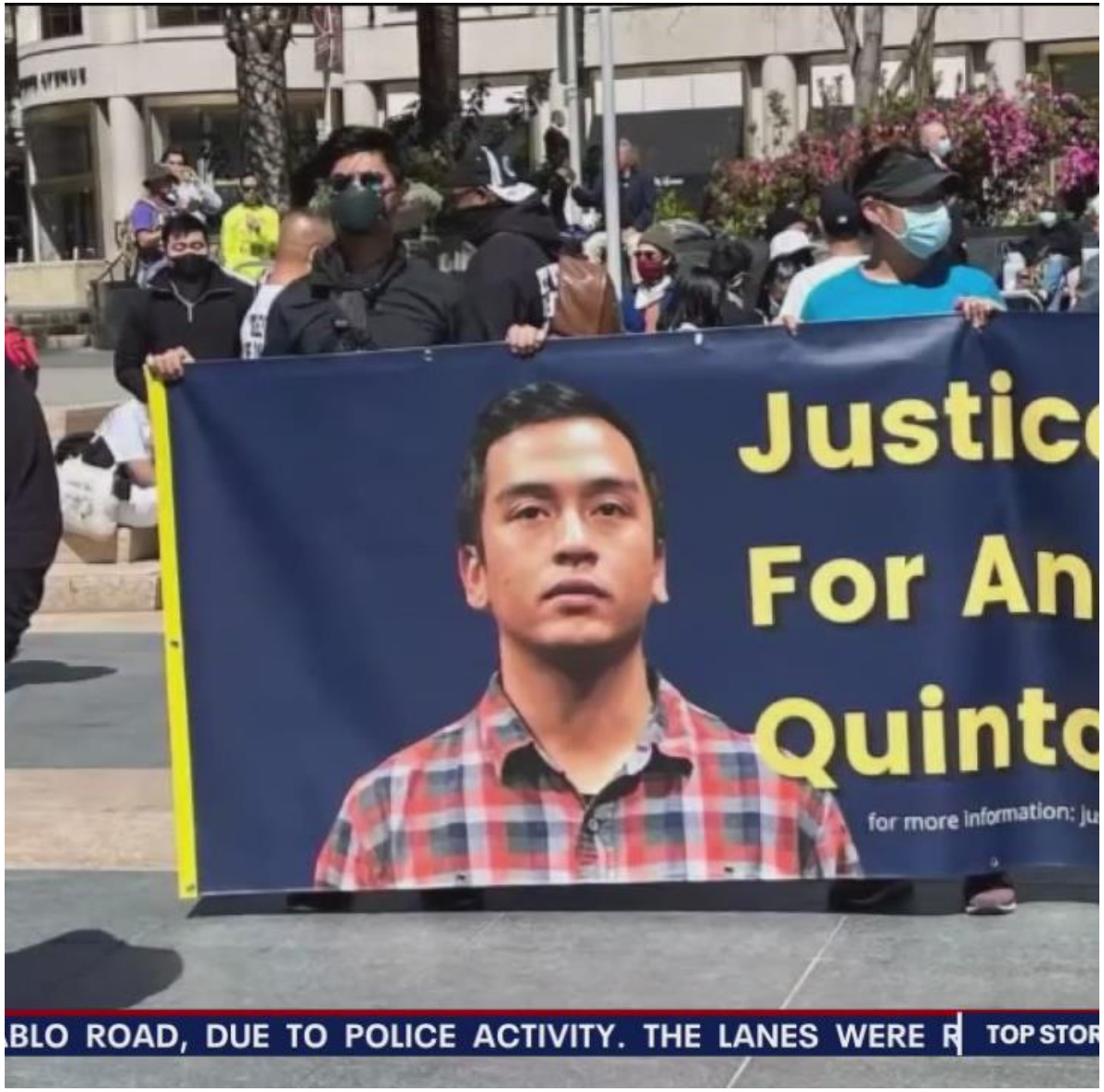
PURPOSE

Assembly Bill 1608 seeks to ensure that localdeath investigations are conducted independently and objectively, reducing any perception of biased investigative medical examinations when determining the cause of death of an individual, including those in custody.

rarely, if ever, happens independent of police involvement.

The increasing attention around excited delirium prompted the American Medical Association to recently reject the term. Additionally, neither the World Health Organization, nor the American Psychiatric Association, recognize this term

CALIFORNIA
ASSEMBLY BILL 1608
ASSEMBLYMAN MICHAEL GIPSON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For An
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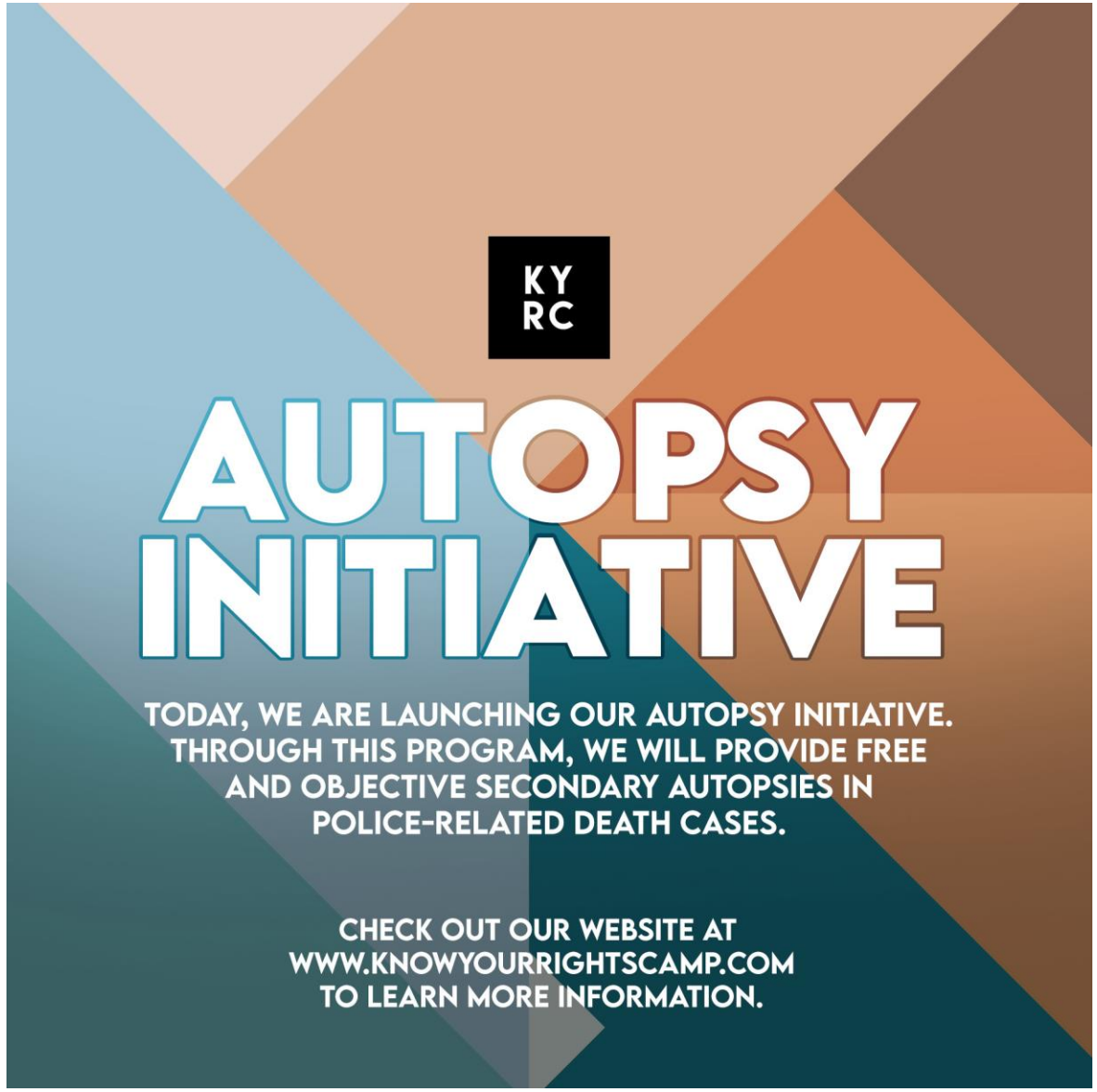
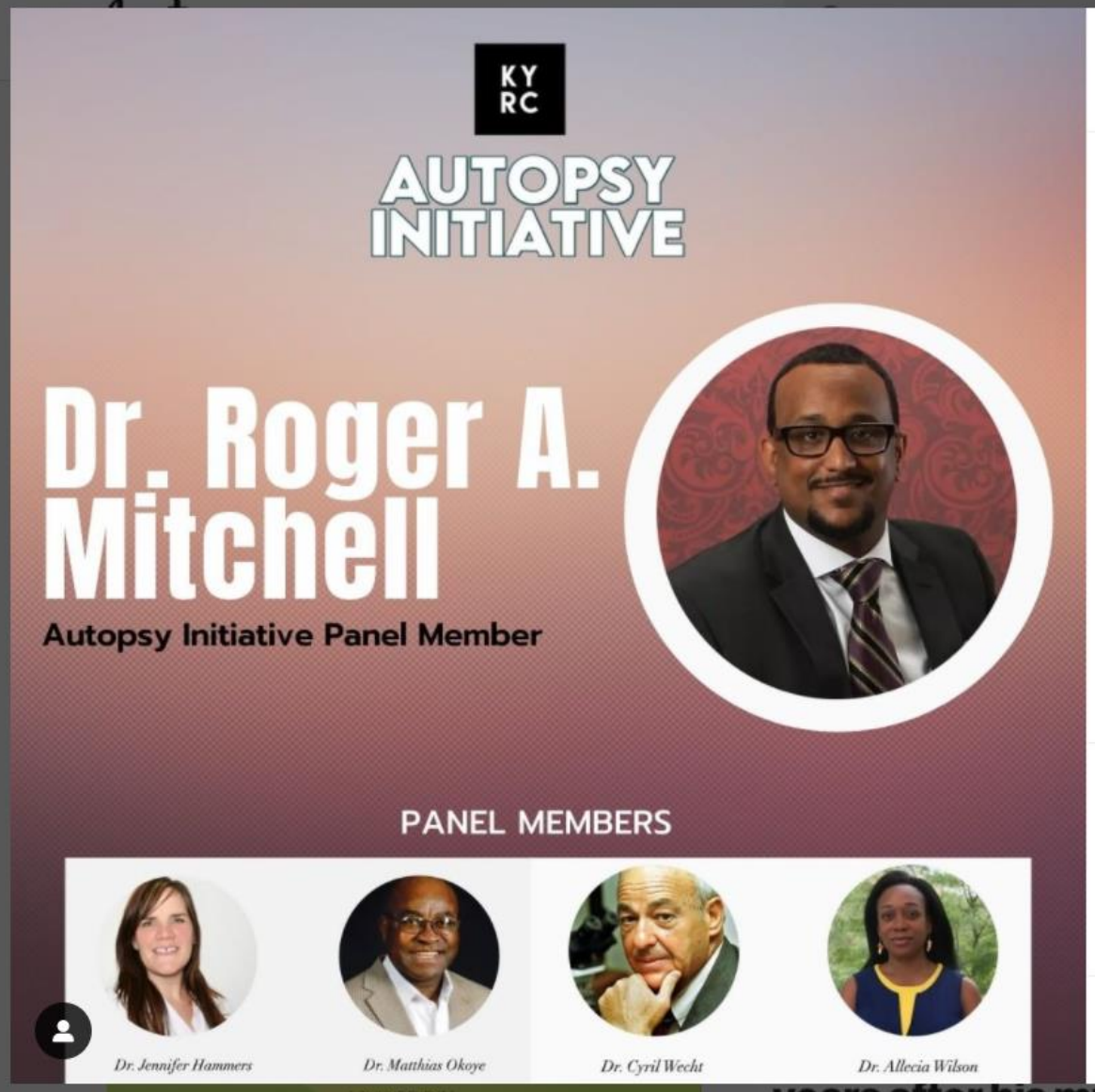
for more information: ju
ABLO ROAD, DUE TO POLICE ACTIVITY. THE LANES WERE R
TOP STOR

FAMILY OF ANGELO QUINTO


KY
RC
AUTOPSY
INITIATIVE
TODAY, WE ARE LAUNCHING OUR AUTOPSY INITIATIVE.
THROUGH THIS PROGRAM, WE WILL PROVIDE FREE
AND OBJECTIVE SECONDARY AUTOPSIES IN
POLICE-RELATED DEATH CASES.
CHECK OUT OUR WEBSITE AT
WWW.KNOWYOURRIGHTSCAMP.COM
TO LEARN MORE INFORMATION.

KNOW YOUR RIGHTS CAMP



roger.mitchell74

roger.mitchell74 I'm honored to join the panel with my colleagues, at the request of Colin Kaepernick's Know Your Rights Camp, to lead the Autopsy Initiative!

Our initiative includes a team of board-certified pathologists that will work objectively, efficiently, and diligently to actively seek the truth to provide the victims' families with the most medically sound cause of death.

The Autopsy Initiative will fully cover the cost of an autopsy if you are selected for the initiative.

Thank you to the @yourrightscamp for developing a critical initiative that leads to justice for all.

Liked by **angeliquemitch** and **87 others**

MARCH 10

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[ONLINE EVENT]

years after his murder


Keep
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VIOLENCE AS A PUBLIC HEALTH ISSUE

The Medicolegal Death Investigation Community is Critical to understanding the depth and scope of Death in Custody

HOWARD UNIVERSITY 1867 | Department of Pathology College of Medicine

Medicolegal Death Investigation – International Community of Practice (MLDI-ICoP) at Howard University Department of Pathology

- Funded by the CDC-Foundation/Bloomberg Data for Health
- Supports nearly 30 Countries
- 120 members
- Provides technical support and training in MLDI, Forensic Pathology, and Pathology
- Monthly Virtual Morning Rounds
- Free and open to individuals and organizations
- Launching E-Hub in Fall 2022
  - Online resources, Peer-to-Peer Mentorship, Discussion Forum, Technical Assistance
  - Continuing Medical Education (CME) Credit available

For more information email mldi_icop@howard.edu


KE
AIR

Department of Pathology
College of Medicine

Thank you!

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