NOTE

DORMANT DATA: WHY AND HOW TO MAKE GOOD USE OF DEATHS IN CUSTODY REPORTING

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I. Introduction

From 2001 to 2006, roughly 3,000 individuals died each year while in the custody of state prison facilities across the United States.[1] Another 1,000 died in locally run jails.[2] Many of these roughly 4,000 annual deaths are inevitable, but many are also preventable. The latter category (i.e., preventable deaths) should never be viewed as an acceptable statistic. The United States federal and state governments are, through their own criminal justice policies, responsible for who gets placed in custody and for how long. They are also ultimately responsible for the conditions of such confinement. Consequently, governments are obliged to meet the needs of individuals they place behind bars, and preventable deaths represent a categorical failure to meet that obligation.

Although courts have explicitly recognized this burden, they have promulgated a counterproductive standard for enforcing it. By requiring a subjective showing of "deliberate indifference"[3] to the plight of prisoners on the part of officials, courts have encouraged prison and jail officials to be ignorant of any systemic issues that have not become catastrophic. There is no single solution to this conundrum, but significant progress can be made with a relatively simple step. Deaths in custody ("DIC") information can be used to encourage transparency and accountability in a system that currently lacks it. This is information that we already have, and it can be used to assess and address major problems (on the national, state, and local scale) before they become catastrophic. If DIC data is analyzed and findings are submitted to the relevant officials, willful ignorance becomes much less viable as a defense. But more importantly than that, using DIC data in this way espouses a more constructive criminal justice policy—that justice officials should look towards affirmatively meeting their obligation to care for those in its custody, rather than doing just enough to avoid civil liability to inmates.

In Part II of this Note, I begin by discussing the current "deliberate indifference" standard that governs whether detainees' conditions of confinement constitute cruel and unusual punishment. This discussion will

1. Christopher J. Mumola & Margaret E. Noonan, *Deaths in Custody Statistical Tables*, BUREAU OF JUSTICE STATISTICS, 3 (2009), *available at* http://www.bjs.gov/content/dcrp/dcst.pdf.

2. *Id.* at 21.

3. *See infra* Part II.B.

include the United States Supreme Court's reasoning behind the standard, as well as the problems that having such a standard create. Next, in Part III, I examine the current requirements governing the reporting of deaths in custody at both the federal and state levels. In Part IV, I discuss realistic options concerning how DIC data may be used to have an immediate positive impact on our federal and state detention facilities, and how this impact may undo much of the danger associated with the United States Supreme Court's "deliberate indifference" standard. Finally, I provide a few illustrations using currently existing DIC data in Part V.

II. The Current Standard for Conditions of Confinement, and the Incentives It Creates

A. Governments Have an Obligation to Meet the Basic Needs of Those in Custody

The moment an inmate is placed behind bars, it is the duty of the State to provide for his or her basic needs.[4] Sharon Dolovich provides a compelling reason for placing such a burden on governments: "For the duration of the sentence, prisoners may not go where they would like, associate with whom they choose, or otherwise freely define the terms of their own existence. But perhaps even more debilitating, incarcerated prisoners are deprived of the capacity to provide for their own needs."[5] This final deprivation—preventing inmates from providing for their own needs—is so fundamental that it is often overlooked. States cannot take away a person's ability to feed, clothe, protect, or care for himself without subsequently meeting those very basic needs.

The United States Supreme Court has recognized this "basic needs" obligation—most often in the context of Eighth Amendment, "cruel and unusual punishment,"[6] cases: "The [Eighth] Amendment also imposes duties on these officials, who must provide humane conditions of confinement; prison officials must ensure that inmates receive adequate food, clothing, shelter, and medical care, and must 'take reasonable measures to guarantee the safety of the inmates.'"[7] The Court sees the State as being directly responsible for meeting such needs: "[H]aving stripped them of virtually

4. As used in this Note, the term "basic needs" refers to those things (tangible or intangible) that are necessary to maintain adequate physical and mental health for the individual inmate as well as the inmate population at large. This includes biological health, as well as personal safety and security. *See* DeShaney v. Winnebargo Cnty. Dept. of Soc. Services, 489 U.S. 189, 199–200 (1989). In a sense this could be considered synonymous with providing the "bare minimum." However, it is important to note that there is a significant difference between the bare minimum for survival and the bare minimum for adequate overall health.

5. Sharon Dolovich, *Cruelty, Prison Conditions, and the Eighth Amendment*, 84 N.Y.U. L. REV. 881, 911 (2009).

6. U.S. CONST. amend. VIII.

7. Farmer v. Brennan, 511 U.S. 825, 832 (1994) (quoting Hudson v. Palmer, 468 U.S. 517, 526–27 (1984)).

every means of self-protection and foreclosed their access to outside aid, the government and its officials are not free to let the state of nature take its course."[8] This applies to medical care[9] as well as conditions and treatment in correctional facilities: "Taken together, [the Supreme Court cases] stand only for the proposition that when the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being."[10]

Each of these cases (and note that these are not the only ones)[11] articulates the same unambiguous principle: when a government imposes its coercive power to deprive an individual of his ability to provide for himself, the government has an unavoidable obligation to meet that individual's basic needs. The issue of whether and how a government meets this burden is discussed in Part III. But from the outset, it should be observed that while the precise standard of meeting basic needs may be up for debate, it is clear that preventable deaths in custody demonstrate an institutional failure to meet those basic needs. This is precisely why information regarding DIC can be extremely useful toward assessing and addressing conditions-of-confinement issues.[12]

B. At What Point Does a Government Fail to Meet its Obligation?

Practically speaking, there is no clearly-defined threshold where conditions or treatment in correctional facilities are such that they are deemed inadequate to meet the basic needs of inmates. Substantial litigation on the subject, however, does provide at least an indication of what is adequate as a matter of fundamental right. Nearly all of the cases dealing with such conditions are brought under 42 U.S.C. § 1983, which provides a mechanism through which individuals can sue in civil court when they have been deprived of a fundamental (often constitutional) right or liberty.[13]

Estelle v. Gamble[14] is the seminal United States Supreme Court case dealing with prison conditions and the Eighth Amendment. J.W. Gamble

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8. *Id.* at 833.

9. *See, e.g.*, Estelle v. Gamble, 429 U.S. 97, 103 (1976) (noting that failure to meet certain medical needs "may actually produce physical 'torture or a lingering death'" (quoting *In re* Kemmler, 136 U.S. 436, 447 (1890))).

10. DeShaney v. Winnebago Cnty. Dept. of Soc. Services, 489 U.S. 189, 199–200 (1989).

11. In articulating the above principles in *Farmer*, *Estelle*, and *Deshaney*, the Court cites to numerous other Supreme Court cases for support. *See, e.g.*, Youngberg v. Romeo, 457 U.S. 307, 317 (1982); Revere v. Massachusetts Gen. Hosp., 463 U.S. 239, 244 (1983); Hudson v. Palmer, 468 U.S. 517, 526–27 (1984); Washington v. Harper, 494 U.S. 210, 225 (1990).

12. *See infra* Part IV.

13. *See* 42 U.S.C. § 1983 (2010). The statute provides in part that "[e]very person who . . . subjects, or causes to be subjected, any citizen . . . to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law . . . ." *Id.*

14. 429 U.S. 97 (1976).

was an inmate of the Texas Department of Corrections.[15] Gamble injured his back while on a prison work assignment.[16] Although Gamble received medical care while in prison, he brought suit under Section 1983 to contest the poor quality of the medical treatment.[17] Gamble was in and out of administrative segregation and solitary confinement because he refused to work due to his medical issues, and, on several occasions, he was denied the opportunity to see the medical staff despite being in severe pain.[18]

Denying Mr. Gamble's claim, the Supreme Court initially recognized the obligation of the states to meet the basic needs of those in its custody.[19] And while the Court acknowledged that some level of deficient medical care could constitute an Eighth Amendment violation, it held that Gamble would have to "allege acts or omissions sufficiently harmful to evidence *deliberate indifference* to serious medical needs," in order to make a successful claim.[20] Later, in *Wilson v. Seiter*, the Supreme Court extended this holding to cases dealing with prison conditions generally (as opposed to a single individual's treatment, which was the issue in *Estelle*).[21]

While the term "deliberate indifference" became widely used in Eighth Amendment conditions-of-confinement cases after *Estelle* and *Wilson*, it took nearly eighteen years for the Supreme Court to actually define the term.[22] In *Farmer v. Brennan*, the Supreme Court did not address the issue on the macro level (i.e., conditions of confinement), but it did resolve a long-standing dispute between lower courts concerning what exactly "deliberate indifference" entailed.[23] Dee Farmer, a federal prisoner, was a transgender inmate who complained that corrections officers placed her in the general population of male prisoners despite knowledge that (1) the facility had a violent environment, and (2) that individuals projecting female characteristics (like Farmer) were especially vulnerable.[24]

In deciding how to articulate a cohesive standard for deliberate indifference, the Supreme Court ultimately determined that the proper test was akin to a criminal recklessness standard: i.e., an actor is only liable where he "disregards a risk of harm of which he is aware."[25] The Court chose this standard because it maintained a level of subjective intent (in contrast to the civil recklessness standard),[26] which is consistent with the Court's earlier

15. *Id.* at 98.
16. *Id.* at 99.
17. *Id.* at 99–101.
18. *Id.* at 100–01.
19. *Id.* at 103–04.
20. *Id.* at 106 (emphasis added).
21. Wilson v. Seiter, 501 U.S. 294, 302–04 (1991).
22. *See* Farmer v. Brennan, 511 U.S. 825, 835 (1994) (acknowledging that "we have never paused to explain the meaning of the term 'deliberate indifference'").
23. *See id.* at 832.
24. *Id.* at 831.
25. *Id.* at 837.
26. *See id.*

opinions in *Estelle* and *Wilson* (among other cases).[27] This subjective element, however, exists only to the extent that the defendant is aware of a substantial *risk*; it does not require absolute knowledge or belief that a specific harm *will* occur.[28] The Court summarized its holding by stating that, "a prison official may be held liable under the Eighth Amendment for denying humane conditions of confinement only if he knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it."[29]

C. Perverse Incentives

The above holdings establish the current jurisprudence regarding conditions of confinement cases. Unfortunately, these cases tell very little about what actually constitutes cruel treatment or inadequate care (at either the micro or macro levels). Indeed, making this determination appears to be so deeply rooted in specific facts that promulgating a single standard may be impossible. Nonetheless, there is at least one critical lesson that can be taken away from the cases of *Estelle*, *Wilson*, and *Farmer*: there is an extremely high threshold for holding corrections officers and facilities accountable for their failure to adequately provide for inmates' basic needs. The subjective "deliberate indifference" standard introduced in *Estelle*,[30] expanded in *Wilson*,[31] and explained in *Farmer*,[32] places a significant burden on the plaintiff by requiring him to demonstrate both that corrections officers or officials (1) were *in fact* aware of a dangerous situation, and (2) that they made no *attempt* to avoid or remedy the situation.[33]

This effectively creates a perverse incentive for correctional officers and facilities. Under this regime, there are logically two ways for officials to avoid getting in trouble: (1) be diligent in meeting the basic needs of all the inmates in their custody; or (2) keep their heads buried in the sand.[34] One of these is far more difficult than the other. In fact, option (1) is becoming increasingly difficult as jail and prison funding decreases without any change in criminal justice policy.[35] It is true that, regardless of what a corrections officer or official *claims* to know, a fact-finder may always determine that he or she was at least aware enough of a certain risk to satisfy the subjective

27. *See id.* at 839–40.

28. *Id.* at 842.

29. *Id.* at 847.

30. Estelle v. Gamble, 429 U.S. 97, 104 (1976).

31. Wilson v. Seiter, 501 U.S. 294, 302–04 (1991).

32. *Farmer*, 511 U.S. at 835.

33. *See id.* at 834.

34. Joanne Mariner provides a critical look at how such perverse incentives play out in the context of one facet of conditions of confinement: prison rape. *See* Joanne Mariner, *Deliberate Indifference, State Authorities' Response to Prisoner-on-Prisoner Sexual Abuse, in* PRISON NATION: THE WAREHOUSING OF AMERICA'S POOR 232 (Tara Herivel & Paul Wright eds., 2003).

35. *See, e.g.*, *infra* Part II.D.

element of the test.[36] But this concession, if it does anything meaningful, only changes the degree to which the current system creates a perverse incentive.

Ideally, we want corrections officers and officials—at both the micro and macro levels—to take an active interest in what is going on in their facilities and how they can be improved. The deliberate indifference standard discourages any such measures because, by their very nature, they will make officials aware of problems that they are ill-equipped to deal with at that point in time. The line of cases from *Estelle* to *Farmer* encourages officials to wait until any underlying problems percolate to the point that the officials cannot make a plausible excuse for ignorance of the inadequate conditions. The obvious problem with this method is that, by that point, very little can be done by officials to remedy the problem without significant immediate costs.

D. When Things Go Really Wrong: A California Case Study

One could argue that this is precisely what happened in the recent high-profile case of *Brown v. Plata*.[37] *Plata* involved a class action suit brought by California prisoners to contest the poor medical care in California prisons that has resulted from severe overcrowding.[38] As of 2010, California prisons were operating at about 195% capacity.[39] The implications of this were sweeping and devastating,[40] but they were also foreseeable. In 1996, Congress passed the Prison Litigation Reform Act (PLRA).[41] One of the provisions of this legislation was to provide very limited circumstances under which a court order could be used to release inmates from custody.[42] The Supreme Court held that all these conditions were met in *Plata*.[43] Consequently, the Court upheld an order for California to reduce its inmate population to about 137.5% in two years.[44]

It would be difficult to prove whether the California corrections debacle was the result of the current deliberate indifference standard's encouragement of ignoring problems until they become unavoidable and

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36. *See supra* notes 25–29 and accompanying text.

37. 131 S. Ct. 1910 (2011).

38. *See* Solomon Moore, *California Prisons Must Cut Inmate Population*, N.Y. TIMES, Aug. 5, 2009, at A10, *available at* http://www.nytimes.com/2009/08/05/us/05calif.html; Bob Egelko, *State Submits Plan to Reduce Prison Population*, SAN FRANCISCO CHRON., Nov. 13, 2009, at A1, *available at* http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2009/11/13/MNMV1AJNHV.DTL&type=printable.

39. Lyle Denniston, *Argument Preview: Crowded Prisons, Inmates' Rights*, SCOTUS BLOG (Nov. 28, 2010, 5:20 PM), http://www.scotusblog.com/?p=109414.

40. An oft-quoted statistic by the courts was that, due to California's inadequate medical care, "[a]s of mid-2005, a California inmate was dying needlessly *every six or seven days*." *See, e.g., Coleman v. Schwarzenegger*, Nos. CIV S-90-0520 LKK JFM P., C01-1351 TEH., 2009 WL 2430820, at *1 (E.D. Cal. and N.D. Cal. Aug. 4, 2009).

41. 18 U.S.C. § 3626 (2010).

42. Denniston, *supra* note 39.

43. Brown v. Plata, 131 S. Ct. 1910, 1942–43 (2011).

44. *Id.* at 1945–47. This is estimated to be about 40,000 prisoners. *See* Denniston, *supra* note 39.

catastrophic. Whether the standard did or did not have an impact on *Plata*, however, is unimportant in this discussion. For our purposes, *Plata* represents two concepts: (1) conditions-of-confinement problems are just as relevant today as they were when cases like *Estelle*, *Wilson*, and *Farmer* were decided; and (2) the result of being *reactive* rather than *proactive* toward conditions of confinement can truly be devastating.[45] Hence, even if the deliberate indifference standard did not directly lead to the issues involved in *Plata*, the case does represent a trend against proactive policies. This is a trend that needs to be reversed.

Had policymakers been better informed by prison officials regarding impending dangers, they may have been able to formulate a more successful proactive response. An in-depth look at California's corrections policy reveals that *Plata* was more of an inevitable result than it was a freak occurrence. There was no shortage of ways in which California policymakers could have actively avoided this result. For example, California likely could have made substantial progress toward improving overcrowding if it had addressed something experts had been pointing to for years: improving parole policy. First, California could simply have started paroling more inmates.[46] Second, California could have changed its policy regarding technical parole violations (i.e., violations solely because the parolee breaks a term of the parole agreement, not because he or she broke any law or is deemed to be a threat to society). Particularly in the face of its current overcrowding problem, it is astonishing to realize that over 66% of all individuals paroled in California return to prison over a three-year period.[47] Thirty-nine percent out of that 66% are sent back to prison for technical parole violations.[48] Such violations might include failing to meet with a parole officer or leaving the supervision area (such as the city or state) without notice.[49]

Policymakers also could have enacted changes to California's three strikes laws, which were responsible for much of the overcrowding in the state's prisons.[50] Finally, an increased reliance on probation could likewise have led to substantial reductions in prison populations.[51] In times when

45. California chose a reactive policy by waiting until conditions became so bad that they constituted a violation of basic human rights. *See supra* notes 38–39 and accompanying text. As a result, the remedy will be a tough pill to swallow for the state. *See supra* notes 40–44 and accompanying text.

46. *See generally* Rachel F. Cotton, Comment, *Time to Move On: The California Parole Board's Fixation with the Original Crime*, 27 YALE L. & POL'Y REV. 239 (2008) (arguing for a more lenient parole system in California).

47. RYKEN GRATTET, JOAN PETERSILIA & JEFFREY LIN, PAROLE VIOLATIONS AND REVOCATIONS IN CALIFORNIA 5 (2008), http://www.ncjrs.gov/pdffiles1/nij/grants/224521.pdf.

48. *Id.*

49. *Id.* at 12.

50. *See, e.g.*, Sara J. Lewis, Comment, *The Cruel and Unusual Reality of California's Three Strikes Law:* Ewing v. California *and the Narrowing of the Eighth Amendment's Proportionality Principle*, 81 DENV. U. L. REV. 519 (2003); Solomon Moore, *The Prison Overcrowding Fix*, N.Y. TIMES, Feb. 11, 2009, at A17, *available at* http://www.nytimes.com/2009/02/11/us/11prisons.html (touching on California's parole policy as well).

51. *See generally* James Q. Wilson, *Dealing with the High-Rate Offender*, 72 PUB. INT. 52, 66–70 (1983) (endorsing a view of "selective incarceration" in which more low-rate offenders are put on

states had fewer budget woes, policymakers could address overcrowding by building more facilities; but in today's budget climate, building new jails and prisons is not a feasible option for many states. In light of *Plata*, California will now apparently have to implement a rushed—and far less effective—combination of the above suggestions.[52]

Undeniable problems exist with our current jurisprudence toward conditions of confinement. And while improvements may be made at the court level by revising the current standard,[53] part of the problem may be the very fact that we are relying on the courts to oversee such conditions. It is difficult to imagine a realistic standard of liability that does *not* lead to corrections officers and officials being focused on avoiding litigation rather than affirmatively meeting their obligation to care for inmates' basic needs. Fortunately, DIC data can be used regardless of the legal standard adopted by the courts. If that standard remains "deliberate indifference" (which seems likely for the foreseeable future), then DIC data may be used to at least partially overcome the perverse incentives that currently exist. Additionally—regardless of the legal liability standard imposed—DIC data can be used to affirmatively address potential problems before they become uncontrollable. The best part, however, is that the data is available right now.

III. Deaths in Custody Information is Available and Valuable

A. Deaths in Custody Reporting at the Federal Level

1. Birth of the Death in Custody Reporting Act

Congress took a huge step toward uniform reporting of inmate deaths in jails and prisons when it passed the Death in Custody Reporting Act of 2000 ("DICRA 2000").[54] This legislation amended 42 U.S.C. § 13704 to add the condition that, for a state to be eligible to receive a "truth-in-sentencing incentive grant,"[55] the state must "follow guidelines . . . in reporting, on a

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probation instead of behind bars).

52. *See supra* notes 38–39, 43–44 and accompanying text.

53. *See* Dolovich, *supra* note 5, at 964–79 (proposing a legal standard to replace "deliberate indifference").

54. Pub. L. No. 106-297, 114 Stat. 1045 (2000).

55. *See* 42 U.S.C. § 13704 (2010). Before DICRA, eligibility was conditioned almost entirely on the State's participation in enacting truth-in-sentencing laws that require certain offenders to serve at least 85 percent of their sentence imposed (hence the title of the grant award). *Compare* Omnibus Consolidated Rescissions and Appropriations Act of 1996, 42 U.S.C. 13704 (1996) (having no provision in 42 U.S.C. § 13704 requiring state Attorney Generals to report information of inmate deaths), *with* Death In Custody Reporting Act of 2000, 42 U.S.C. § 13704(a)(2) (2000) ("[A] State has provided assurances that it will follow guidelines established by the Attorney General in reporting, on a quarterly basis, information regarding the death of any person who is in the process of arrest, is en route to be incarcerated, or is incarcerated at a municipal or county jail, State prison, or other local or State correctional facility (including any juvenile facility) that, at a minimum, includes—(A) the name, gender, race, ethnicity, and age of the deceased; (B) the date, time, and location of death; and (C) a brief description of the circumstances surrounding the death.").

quarterly basis, information regarding the death of any person who is in the process of arrest, is en route to be incarcerated, or is incarcerated at a municipal or county jail, State prison, or other local or State correctional facility . . . ."[56] DICRA 2000 required that, at a minimum, such reporting include "(A) the name, gender, race, ethnicity, and age of the deceased; (B) the date, time, and location of death; and (C) a brief description of the circumstances surrounding the death."[57]

DICRA 2000 passed both the House and Senate with very little opposition.[58] There are several potential explanations for this widespread support. First, the support could have simply reflected that the bill would have very little financial or political impact.[59] Second, the Department of Justice had already investigated the feasibility of such a measure and had reported that the goal to have a single source for annual death in custody statistics was achievable.[60] Third, such statistics were already being "gathered on an annual and a voluntary basis for Federal and State deaths and on a 5-year voluntary basis for county and local jails."[61] Fourth, officials may have recognized that having such a reporting system constitutes a good policy for overseeing and improving conditions in prisons and jails nationwide. While DICRA 2000's support was undoubtedly due to some combination of these four factors, it is the fourth factor—i.e., policy—that this Note examines in more depth.

DICRA 2000's sponsor, Rep. Asa Hutchinson of Arkansas, expressed both a micro and macro purpose for the bill. On its micro purpose, Rep. Hutchinson articulated a deep concern for the lack of accountability and transparency in United States jails and prisons regarding inmate deaths.[62] According to Rep. Hutchinson, "[a]n estimated 1,000 men and women die questionable deaths each year while in police custody or in jail."[63] Though he did not explain what made this grouping of deaths "questionable," he did offer anecdotes of two Arkansas individuals whose deaths were listed as suicides while the circumstances surrounding their deaths—particularly in light of the relatively minor nature of their offenses—suggested otherwise.[64] Rep. Hutchinson believed that DICRA 2000 could "serve as a deterrent to future misconduct by wrongdoers who will know that someone will be monitoring their actions."[65] On the bill's macro purpose, Rep. Hutchinson

56. 42 U.S.C. § 13704(a)(2) (2010).

57. *Id.* The Attorney General would, however, be able to establish guidelines in addition to these criteria. *See id.*

58. *See* 146 CONG. REC. H6736 (daily ed. July 24, 2000).

59. After all, its enforcement mechanism was to withhold funds that would already have been appropriated for States eligible for truth-in-sentencing grant money. *See* 42 U.S.C. § 13704(a)(2) (2010).

60. 146 CONG. REC. H6736 (daily ed. July 24, 2000) (statement of Rep. Asa Hutchinson).

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.*

65. *Id.*

believed it would "provide openness in government and . . . bolster public confidence and trust in our judicial system."[66]

Cosponsor Rep. Bobby Scott of Virginia also saw a clear macro purpose for the bill, arguing that "with no one looking at these deaths from a systematic point of view, we do not know whether there is any pattern or practice relating to such deaths nor whether there is any training needed amongst law enforcement officials which could limit such occurrences or anything else."[67] Rep. Scott expressed hope that such reporting would allow Congress "to get a handle on the nature and extent of what I believe to be a serious problem; we just do not know the extent."[68] Rep. Scott additionally saw a micro benefit to the legislation, in that requiring such a report and description of the incident for all deaths would "discourage the misconduct, or questionable conduct, against those in custody by their custodians."[69]

Although this Note strongly advocates DIC reporting measures for macro benefits, it is unclear to what extent such measures can have the micro benefits endorsed by Rep. Hutchinson and Rep. Scott. The idea that a federal law like DICRA 2000 can have a direct effect on custodians' treatment of those in custody runs into two problems: (1) custodians themselves have no direct incentive to fully and accurately report deaths in custody;[70] and (2) even to the extent that they do, descriptions of circumstances can be manipulated so as to avoid incriminating evidence against the custodian. On the first, the federal legislation itself contains no penal sanctions for failing to fully and accurately report on DIC—nor could it.[71] The best the federal government can do is to threaten to withhold certain grant awards.[72] The second concern is admittedly an issue for both micro and macro uses of the data, but it stands to reason that falsifying reports is a much more likely phenomenon where the data may be used to sue or prosecute a custodian. From a broad perspective, the aggregate of such reports may still be able to produce meaningful insights into incarceration conditions despite the

66. *Id.*

67. 146 CONG. REC. H6736 (daily ed. July 24, 2000) (statement of Rep. Bobby Scott). Whether Mr. Scott realized it or not, this turns out to be a great characterization of the utility of such information when it comes to improving incarceration conditions and addressing Eighth Amendment concerns. *See infra* Part IV.

68. 146 CONG. REC. H6736 (daily ed. July 24, 2000) (statement of Rep. Bobby Scott).

69. *Id.*

70. *See infra* Part IV.B.

71. While it is true that DICRA does threaten to withhold federal funding from states not in compliance, this enforcement provision in and of itself does little to deter *individual* wrongdoers—who are the primary focus of the micro approach. This is a major reason that individual states need to have similar reporting requirements: they can attach penal sanctions to the failure to comply. *See infra* Part IV.B.

72. Another option for the federal government is to conduct hearings and require non-compliant jurisdictions to explain themselves. This is currently what is happening with another justice system reporting statute: the Prison Rape Elimination Act. *See, e.g.*, *Fluvanna Women's Prison Testifies on Rape Report*, ASSOCIATED PRESS, Apr. 26, 2011, *available at* http://www.newsplex.com/home/headlines/120693019.html.

presence of a small number of falsified reports.[73] The specific macro benefits of DIC reporting are discussed in more detail in Part IV.

2. Death of the Death in Custody Reporting Act of 2000

According to the U.S. Department of Justice, DICRA 2000 expired in 2006.[74] Regardless, the legislation was rendered impotent long before when no funds were appropriated for the Truth in Sentencing Incentive Grant fund as of FY 2002.[75] Fortunately, neither of these events killed the collection of data. The Bureau of Justice Statistics (BJS)[76] initiated the Deaths in Custody Reporting Program (DCRP) in 2000 in response to DICRA.[77] Since that time, BJS has continued to collect and analyze statistics on DIC.[78] Not only has BJS carried on the DCRP past both the elimination of Truth in Sentencing Incentive Grant funds and the expiration of DICRA 2000, but it has done so with remarkable success.[79] According to BJS, the agency has been able to obtain participation of nearly all local jail jurisdictions (roughly 99%), and 100% of state departments of corrections.[80] Although BJS has historically collected data pertaining to deaths occurring during the process of arrest as a part of the DCRP, such data is now collected under a separate BJS program.[81]

One can only speculate as to why BJS has been able to maintain such a high rate of participation in what now appears to be a completely voluntary program. One explanation is simply that the bureaucracy for making the reports was already put in place when reporting was required, making it a relatively low administrative burden to continue doing so. Another explanation is that many states have laws requiring that such reports be made

73. It is worth noting that this is purely a theoretical critique. Little, if any, evidence exists that reports sent to the Bureau of Justice Statistics contain falsified data. The problem, of course, is that even if a report was falsified, it would be extremely difficult to prove.

74. *See* U.S. Dep't of Justice, Office of Justice Programs, *Deaths in Custody Reporting Program, 2012–2015 Solicitation* 4, http://bjs.ojp.usdoj.gov/content/pub/pdf/dcrp15_sol.pdf (last visited Mar. 5, 2011) [hereinafter DCRP Solicitation] ("BJS has obtained the participation of almost all jail jurisdictions, including post-2006 when the DICRA expired.") (describing reporting programs by the Office of Justice Programs).

75. U.S. Dep't of Justice, Office of Justice Programs, *Violent Offender Incarceration and Truth-in-Sentencing (VOI/TIS) Incentive Program*, http://www.ojp.usdoj.gov/BJA/grant/voitis.html (last visited Mar. 5, 2012).

76. The Bureau of Justice Statistics (BJS) is a part of the Office of Justice Programs (OJP). The OJP is itself a branch of the Department of Justice (DOJ).

77. DCRP Solicitation, *supra* note 74, at 3.

78. *Id.*

79. *See id.* at 4 ("BJS has obtained the participation of almost all jail jurisdictions, including post-2006 when the DICRA expired.").

80. *Id.* at 5.

81. *Id.* at 4. While much can be learned from the collection of such statistics, this Note focuses almost exclusively on the conditions of incarceration. For an example of how arrest-related deaths can be analyzed in a concise and practical way, see generally *Across the Nation*, 24 No. 11 QUINLAN, L. ENFORCEMENT EMP. BULL. art. 10 (2007).

and submitted to certain government agencies or officials.[82]

Regardless of why this is the case, one thing is clear: the high participation rate in the DCRP is a good thing. While high participation is just one of several goals the BJS hopes to accomplish through the DCRP, it is a prerequisite benchmark to achieving one of the most important "main goals" of the DCRP: to "[p]rovide accurate, timely, and relevant statistics on and studies of mortality in correctional settings."[83] With a high participation rate, we can be that much more confident that BJS is sufficiently equipped to meet this goal on a national scale.

3. The Birth of a New Death Reporting Act

Recently, Rep. Bobby Scott (cosponsor of DICRA 2000) introduced the Death in Custody Reporting Act of 2009.[84] In many ways, this legislation is an attempt to reauthorize DICRA 2000. However, it is also more expansive in at least three major aspects. First, it is a stand-alone bill, not an amendment to a presently existing statute (as DICRA 2000 was).[85] Second, it broadens the reporting requirement to include Federal law enforcement agencies.[86] Third, it *requires* the Attorney General to study and report on the information produced in compliance with the new DICRA.[87] Such study includes determining how the information can be used to lower deaths in custody; and "examin[ing] the relationship, if any, between the number of such deaths and the actions of management of such jails, prisons, and other specified facilities relating to such deaths."[88] The proposed legislation uses a similar enforcement mechanism to DICRA 2000, but with a different funding source.[89]

One may wonder how necessary such a bill is considering BJS's success in voluntarily attaining and analyzing information on DIC. Along these lines, the second and third changes listed above are significant. Requiring the inclusion of federal law enforcement agencies is a significant step toward having a comprehensive reporting system. Perhaps more importantly—in contrast to state-level reporting—the federal government is able to directly address any deficiencies it perceives in the federal corrections system. Furthermore, in requiring the Attorney General to affirmatively study and report on the statistics ensures that BJS's efforts on collection and analysis are not entirely in vain. An argument for a practical application of such analysis can be found in Part IV of this Note; but for now, it ought to be sufficient to say that nearly *any* analysis and report by the Attorney General

82. *See infra* Part III.B.

83. DCRP Solicitation, *supra* note 74, at 5.

84. H.R. 738, 111th Cong. (2009) (as passed by the House, Feb. 4, 2009).

85. *See id.*

86. *Id.* at Sec. 3.

87. *Id.* at Sec. 2(f), Sec. 3(b)–(c).

88. *Id.*

89. *See id.* at Sec. 2(c)(2).

is preferable to none. DICRA 2009, like its predecessor, received much support in the House of Representatives: passing with a vote of 407 to 1.[90] The bill currently sits in the Senate Committee on the Judiciary.[91]

B. Deaths in Custody Reporting at the State Level

DIC reporting requirements vary widely from state to state. Many states (about half) do not appear to have any statute that directly addresses reporting requirements of DIC.[92] Among the states that do have such statutes on a statewide level, the requirements tend to fit into one of three general categories: (1) investigation; (2) reporting; and (3) notification. While many statutes include all three components, these categories are helpful primarily to illustrate the *depth* to which states deal with DIC. Statutes with investigative components will usually also have reporting and notification components (Category One), whereas other statutes have only reporting and notification requirements (Category Two), or merely notification requirements (Category Three).

1. Category One: State Statutes with Investigation Components

Statutes with investigative components generally promote both transparency and accountability. The reporting statutes of Texas, New York, and Kansas serve these two functions more than any other state statutes. As such, these statutes provide a good model for other state legislators.

Texas has a detailed statute regulating the reporting of inmate deaths,[93] with a corresponding penal code provision for those who act in violation of the reporting statute.[94] The Texas statute covers the entire reporting process: from the requirement that the facility employee in charge of the inmate notify the nearest justice of the peace of the death, to the inspection and investigation the justice of the peace is to conduct, to the report the justice of the peace must file with the local district judge.[95]

New York's reporting statute deserves particular attention. The statute deals primarily with the "functions, powers, and duties" of the Correction Medical Review Board within the State Commission of Corrections.[96] Under the statute, the board is to investigate the cause and circumstances surrounding the death of *any* inmate of a correctional

90. Guadalupe A. Lopez, *Legislative Updates*, 5 MOD. AM. 57, 58 (2009).

91. *See id.*

92. The statutes in this section were recovered by running the following Westlaw "terms and connectors" search: "(death w/20 inmate or incarcerat! or custody) and record or report." Admittedly, several states may address deaths in custody indirectly, but this Note is only interested in statewide statutes that explicitly address deaths in custody.

93. *See* TEX. GOV'T CODE ANN. § 501.055 (West 2011).

94. *See* TEX. PENAL CODE ANN. § 39.05 (West 2011).

95. *See* TEX. GOV'T CODE ANN. § 501.055 (West 2011).

96. *See* N.Y. CORRECT. LAW § 47(1) (McKinney 2011).

facility.[97] The board is also required to report specifically on the condition of medical care systems in correctional facilities and recommend potential improvements.[98] The statute does contain one clearly mandatory provision, and that is for correctional facility administrators to immediately report the death of an inmate to the board and to submit an autopsy report.[99] The most praiseworthy aspect of the New York statute is that it may be unique by containing provisions governing not only reporting of inmate deaths, but also for using such information to suggest improvements in correctional facilities generally and healthcare more specifically.[100]

The Kansas Bureau of Investigation is required to investigate the circumstances surrounding inmate deaths in Kansas and to prepare a report of its findings.[101] This report is then "made available to the chairperson of the senate judiciary committee and the house corrections and juvenile justice committee of the Kansas legislature . . . ."[102] The report is also subject to Kansas' open records act.[103] An identical statute exists for deaths occurring in the custody of the secretary of corrections or the commissioner of juvenile justice.[104]

While not at the level of the Texas, New York, or Kansas statutes, some state statutes are still more properly considered a part of Category One. For example, North Dakota and Ohio have statutes primarily concerned with reporting, but they also contain implicit investigative components. North Dakota's statute requires the furnishing of all information surrounding a death in custody to the Bureau of Criminal Investigation.[105] Ohio, on the other hand, requires that such information be kept in the Department of Rehabilitation and Correction.[106] In the case of certain types of inmate deaths in Ohio, however, the managing officer is required to make a "special report to the department . . . giving the circumstances as fully as possible."[107] Such information is still not made public.[108]

In contrast to statutes like North Dakota's and Ohio's, some states explicitly require investigation, but have only implicit reporting requirements. Pennsylvania's statute contains a provision requiring the local coroner to investigate the circumstances surrounding deaths in custody "to determine whether or not there is sufficient reason" to believe that the death "resulted from criminal acts or criminal neglect of persons other than the

97. *Id.* at § 47(1)(a).
98. *Id.* at § 47(1)(e).
99. *Id.* at § 47(2).
100. *Id.* at § 47(1)(e).
101. KAN. STAT. ANN. § 19-1935 (West 2011).
102. *Id.*
103. *Id.*
104. *See* KAN. STAT.ANN. § 75-52,147 (West 2011).
105. *See* N.D. CENT. CODE § 12-60-16.2 (2011).
106. *See* OHIO REV. CODE ANN. § 5120.21(A) (West 2011).
107. *Id.* at § 5120.21(A)–(B).
108. *See id.*

deceased."[109] Vermont's statute is primarily focused on notice, with the exception that it requires the state's attorney of the local county to take charge of the body and conduct a preliminary investigation along with the medical examiner.[110] The Maryland statute is similar, but it is concerned specifically with investigation of deaths in custody suspected to be homicides.[111] Arkansas requires that deaths in custody be reported to "[t]he county coroner, prosecuting attorney, and either the county sheriff or the chief of police of the municipality" in which the death occurs.[112] If previous medical history does not explain the cause of death in a correctional facility, Arkansas further requires that the state police are notified.[113]

2. Category Two: State Statutes with Primarily Reporting Components

Several state statutes lack investigative components, but require something more than mere notice of deaths in custody. Such statutes evidence states' concerns with transparency over accountability. Like all the state statutes in this category, California's statute is concerned with reporting information of the circumstances surrounding deaths in custody.[114] Unlike many of these states, however, the California statute requires the agency in charge of the correctional facility to report *directly* to the Attorney General "all facts in the possession of the . . . agency . . . concerning the death."[115] Such reports are public records in California.[116]

The South Carolina reporting statute requires the facility manager to notify the local coroner and to submit a report of the "death and circumstances surrounding it . . . to the Jail and Prison Inspection Division of the Department of Corrections" for all deaths in custody.[117] The Division must retain a permanent record of such reports—although it is unclear what (if anything) is to be done with them.[118] Knowing and willful violation of the South Carolina statute constitutes a misdemeanor and is punishable by a fine not more than one hundred dollars.[119]

Tennessee's statute is primarily a notice statute (i.e., it requires that the district attorney or medical examiner be notified of deaths occurring in custody),[120] but it also requires that the Commissioner of Correction "provide

109. 16 PA. STAT. ANN. § 1237(a)–(b) (2011).

110. 18 VT. STAT. ANN. § 5205 (West 2011).

111. MD. CODE ANN., PUB. SAFETY § 2-301(a)(2)(viii) (West 2011).

112. ARK. CODE ANN. § 12-12-315 (West 2011).

113. *Id.* at § 12-12-315(b). Violation of the Arkansas statute constitutes a Class A misdemeanor. *Id.* at § 12-12-315(c).

114. *See* CAL. GOV'T CODE § 12525 (West 2011).

115. *Id.*

116. *Id.*

117. S.C. CODE ANN. § 24-9-35 (2011).

118. *See id.*

119. *Id.*

120. TENN. CODE ANN. § 38-7-108 (West 2011).

a report of any death of any person in the custody of the department at a department facility . . . to the state senator and representative representing such person."[121] This facet of the Tennessee statute is rare. Indeed, Kansas is the only other state requiring that such reports be made directly to state legislators.[122] What state legislators intend to do with such information is unclear, but the Tennessee and Kansas statutes indicate a very direct interest that their state legislators have taken in local deaths in custody.

3. Category Three: State Statutes with Only Notification Requirements

Many states include death in custody reporting requirements in broad statutes that enumerate several "types" of deaths requiring special notification.[123] While several of these state statutes do contain an "investigative" component, any investigation in this context is geared more toward record keeping than accountability.[124] Consequently, these statutes do not belong in Category One.

Georgia, New Hampshire, and Oklahoma require that a medical examiner be notified so that he or she may determine the cause of death in all cases involving deaths in custody.[125] Colorado and Nebraska contain similar provisions but instead require a local coroner to make the determination.[126] Massachusetts requires any person knowledgeable of a death in custody to notify the chief medical examiner of the location and all "known facts concerning the time, place, manner, circumstances and cause of" deaths in custody.[127] Minnesota's statute is very similar, although it specifically requires that "[f]or deaths occurring within a facility licensed by the Department of Corrections . . . a forensic pathologist . . . [shall] review[] each death and perform[] an autopsy on all unnatural, unattended, or unexpected deaths . . . ."[128]

Connecticut and Rhode Island require that certain government

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121. TENN. CODE ANN. § 4-3-611 (West 2011). Inmates' representatives are determined by their home address. *Id.* For those residing outside of Tennessee, this reporting requirement is not mandatory. *Id.*

122. *See* KAN. STAT. ANN. § 19-1935 (West 2011). The author was unable to find any other statutes with such a requirement.

123. The "types" of deaths enumerated in these statutes commonly include two broader themes: (1) those in which public health is concerned (e.g., disease, poison, drugs), and (2) those occurring under suspicious circumstances (e.g., sudden deaths, unintentional injury, suicide). *See, e.g.*, GA. CODE ANN., § 45-16-24 (West 2011); MASS. GEN. LAWS ch. 38, § 3 (2011); MINN. STAT. ANN. § 390.11 (West 2011); N.H. REV. STAT. ANN. § 611-B:11(II) (2011); OKLA. STAT. ANN. tit. 63, § 938 (West 2011).

124. Many of the "investigations" in these statutes appear to be for the purpose of determining cause of death rather than any legal culpability.

125. GA. CODE ANN., § 45-16-24(b) (West 2011); N.H. REV. STAT. ANN. § 611-B:11(II) (2011); OKLA. STAT. ANN. tit. 63, § 938 (West 2011).

126. *See* COLO. REV. STAT. ANN. § 30-10-606 (West 2011); NEB. REV. STAT. ANN.§ 23-1821 (LexisNexis 2012) (including a penalty for noncompliance).

127. MASS. GEN. LAWS ch. 38, § 3 (West 2011). Noncompliance with the Massachusetts statute for certain medical or law enforcement officials may result in a fine of not more than five hundred dollars. *Id.*

128. MINN. STAT. ANN. § 390.11 (Subd. 1a.) (West 2011).

entities simply keep records of deaths occurring in custody and the details surrounding them.[129] The primary difference between the two statutes is that Connecticut expressly provides that "no person may be denied access to records concerning a person in the custody of the state at the time of death,"[130] while the Rhode Island records "shall be accessible only to the director of the department . . . ."[131]

Upon examination of the various Category One, Two, and Three state statutes, a few common themes emerge: First—and perhaps most significantly—only New York's statute requires that anything be done toward improving conditions of confinement with DIC information.[132] Many states have detailed statutes dealing with DIC, but more should contain improvement provisions like New York's. Second, very few statutes include penalties for noncompliance.[133] This is one of the greatest advantages to having states regulate reporting of DIC—they have the ability to compel individual compliance by threatening criminal sanctions.[134] Third, only half of U.S. states even *address* the issue of DIC. And fourth, no state statute attempts to incorporate the information *already attained* by BJS to assess or improve conditions of confinement within the state. As Part IV suggests, all of these deficiencies can and should be remedied by the states.

IV. Using DICRA to Promote Greater Transparency and Accountability in Corrections Systems

So far, this Note has articulated the Government's unique burden to provide for the basic needs of those it holds in custody, explored the current standard to which governments are held in order to meet this burden, and examined current reporting practices regarding inmate deaths. As we have seen, there are problems that arise every step of the way, but I will argue that—with some feasible improvements—current DIC reporting practices can be used to promote greater transparency and accountability in corrections systems nationwide.

A. Congress Should Pass the Death in Custody Reporting Act of 2009

Passage of DICRA 2009 may be imminent given the wide support of its predecessor in both the House and Senate, and the wide support for the

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129. *See* CONN. GEN. STAT. ANN. § 19a-411 (West 2011); R.I. GEN. LAWS § 40-2-1 (2012). These statutes have not been placed in Category Two because they merely require that certain information be retained by medical examiners—not compiled and submitted.

130. CONN. GEN. STAT. ANN. § 19a-411(b) (West 2011).

131. R.I. GEN. LAWS § 40-2-1 (2012).

132. *See supra* notes 99–100 and accompanying text.

133. Texas and South Carolina are the only two states with such provisions. *See supra* notes 94, 119.

134. This is in contrast to federal legislation, which only makes the broader threat of taking away certain funding. *See* 42 U.S.C. § 13704(a)(2).

current legislation in the House.[135] As discussed above, the legislation appears to be the same as DICRA 2000 with just a few alterations.[136] Particularly significant is the requirement that the Attorney General study and report on statistical findings.[137] Having such a requirement in place is beneficial because ideally it means the Attorney General will utilize the hard work that went into collecting such information to directly address how the justice system as a whole is satisfying its burden of meeting the basic needs of those in custody. The government has a burden to meet the needs of those it holds in custody, and any information that can be used to measure the government's success at meeting those needs should be fully utilized. No information more directly addresses this issue on a system-wide scale than DIC statistics. After all, the preventable death of an inmate must be the most clear-cut and pure expression of the government failing to meet an inmate's most basic needs.[138]

If the Attorney General does study and report on this information, a second benefit could be realized: it would help defeat perverse incentives on at least the federal level. Again, there is no clear way to tell what effect the low "deliberate indifference" standard of care has had on prison officials' efforts (or lack thereof) to improve conditions of confinement, but it seems clear that the current standard at least allows or encourages ignorance of such conditions. DICRA 2009 is far from a comprehensive solution, but it would make the relevant federal officials (and ideally other prison officials) less able to claim ignorance of any systemic issues revealed in the data.

B. Policymakers Should Implement DICRA-like Requirements at the State and Local Levels

For all the reasons listed directly above, similar reporting requirements should be put in place at both state and local levels. Recall that information about inmate deaths is collected at the individual level (i.e., on an inmate-by-inmate basis).[139] Therefore, the exact same statistics that BJS filters through every year can be subcategorized and utilized by states and counties for similar purposes. This is a critical step toward fully utilizing DIC statistics because it results in two benefits *in addition* to those described above under DICRA 2009: (1) since states run their own correctional systems, they would be better positioned to both identify and respond to state-

135. *See* Lopez, *supra* note 90, at 58.

136. *See supra* notes 84–89 and accompanying text. In reality, these alterations may be the only reason for even passing the bill, considering BJS's success in voluntarily acquiring death statistics from jails and prisons. *See* DRCP Solicitation, *supra* note 74, at 3–4.

137. *See supra* note 87 and accompanying text.

138. Of course, many inmates will die of entirely natural causes (e.g., cancer, heart disease, old age). Such data is generally not significant for assessing or improving prison conditions. This information *could* be useful for examining policy decisions such as whether elderly or dying patients should be incarcerated until death, but that is not the focus of this Note.

139. *See supra* notes 77–81 and accompanying text.

wide and even localized problems; and (2) states are in a position to actually enforce the accurate collection of this data.

The first benefit is a huge one. Under DICRA 2009, even if the Attorney General does study and report on the data collected, it would be much more difficult to identify and respond to systemic issues both because different states can have very different deficiencies, and because any changes will be far more effective if they are implemented at the state level (in contrast to simply conditioning eligibility for certain funds on compliance as the federal government must often do).

The second benefit may not be a pressing need, but it is a practical concern. Particularly when budgets are tight, correctional officers and officials may not have any incentive to accurately report on inmate deaths where there is no penalty for the failure to do so. Perhaps more concerning, it may work to discourage the reporting of deaths that are truly symptomatic of a larger problem under a cost-benefit analysis from the correctional officer's perspective. Since there is generally no penalty to the individual officer for inaccurate reporting, even a minor benefit (such as the desire to not draw negative attention to the facility) may encourage a corrections officer to falsely report a death as the result of "natural causes" that was actually the result of a lack of proper treatment. It is worth noting once again that this is not to assert that such falsified reports are actually made; this critique merely acknowledges that these negative incentives exist in the current system.

From a practical standpoint, implementing a statute analogous to DICRA 2009 should be neither difficult nor costly. Corrections officers in every state are already collecting this data.[140] Instead of only sending it to BJS, the state may require that such information be sent to both BJS and whatever agency the state designates to analyze the information. States would most likely give the data to currently existing state agencies capable of refining the data. Which state agency this is will likely vary widely from state to state. Implementation costs would likely be low considering the hard part (collection of information) is already done. Alternatively, Congress, rather than the states, can take the initiative by requiring BJS to analyze DIC data on more jurisdiction-specific grounds and report those findings to the proper state officials.

Precisely *how* DIC data is analyzed is another issue that states must determine. Although this information can be analyzed in a near infinite number of ways, two types of analysis are particularly useful: (1) discerning trends; and (2) comparing different jurisdictions. On the first, DIC data can reveal whether a certain jurisdiction (state, county, or even an individual facility) experiences an abnormal or disproportionate rise or fall in a certain type of death. A spike in suicides, for example, would raise immediate red flags. More subtle trends could be a disproportionate amount of deaths

140. *See supra* notes 80–81 and accompanying text.

related to drug use (indicating a need for stricter contraband policies) or otherwise preventable medical issues (indicating understaffed or lax medical services). The second type of analysis—comparing different jurisdictions—will often be a component of the first, but such studies may also be used more generally. For example, suppose a state or county has a suicide rate of ten people per one hundred inmates. On its own, this information does not say much. Now suppose surrounding states or counties all have a suicide rate around one person per one hundred inmates, or fifteen people per one hundred inmates. Suddenly, this initial number is meaningful to local officials and policymakers who may see an obligation to act accordingly. DIC data can be used in these two ways to examine each type of preventable death (e.g., drugs, suicide, homicide, etc.).

After DIC information is received and analyzed by the designated organization, the state can require the findings to be forwarded to any number of state or local officers, officials, or independent correctional oversight mechanisms.[141] This may include the respective state attorney General, Governor, Lieutenant Governor, certain legislators, or directors of prisons on the state level. Policymakers in general can be an ideal audience for certain findings, since they are some of the best equipped to deal with conditions of confinement issues.[142] On the local level, recipients could include managers of individual jails or prisons, state legislators on a criminal justice policy committee, or even congressional representatives of relevant districts—as the Tennessee statute requires.[143] In each of these cases, some or all of the persons presented with the information may be required to study and respond to the information (as the attorney general under DICRA 2009 must do) by, for example, developing an action plan for addressing any concerns raised by the report. Exactly who should receive and respond to which findings can be left to the determination of the agency (obviously, for example, a local jail manager would not need to respond to a finding that the state's prison system is the national leader in drug-related deaths).

V. Using Deaths in Custody Data: A Few Examples

As described in Part IV above, there is no shortage of ways in which DIC Data can be used by policy makers and officials. The following three examples illustrate practical analysis that may be derived from readily available data.

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141. *See generally* Michele Deitch, *Independent Correctional Oversight Mechanisms Across the United States: A 50-State Inventory*, 30 PACE L. REV. 1754 (2010) (containing a thoroughly compiled list of organizations that would likely be good candidates for receiving and responding to the findings of DIC analysis).

142. *See, e.g.*, *supra* Part II.D.

143. *See* TENN. CODE ANN. § 4-3-611 (West 2011).

A. Example One: Examining Leading Causes of Deaths in Custody

The Bureau of Justice Statistics has published several helpful statistical tables regarding causes of deaths in custody. Among these is a table listing the average annual mortality rate for various causes of death in state prisons.[144] This table identifies the following causes of death from most to least common: illness, AIDS, suicide, homicide, drug/alcohol intoxication, accident, and other/unknown.[145] Among these, illness is far and above the leading cause of death in state prisons—accounting for over 82% of all state prison deaths.[146] AIDS and suicide are tied for the second most common cause of death at about 6% each.[147] The remaining causes of death are roughly equivalent in their rate of occurrence.[148]

Interestingly, these percentages do not hold true for causes of death in local jails (as opposed to the state prisons discussed above). The most notable difference is the rate of suicides. Specifically, there are roughly 43 suicides per 100,000 local jail inmates.[149] This is in contrast to the 16 suicides per 100,000 state prison inmates.[150] The heightened suicide rate in local jails comes with correspondingly lower rates of both illness and AIDS causes of death as compared to the state prison rates.[151]

This data can and should be very valuable to prison officials and policy makers alike. First, it indicates that the most efficient way to prevent deaths in state prisons is to address the administration of medical care. Illness is admittedly a broad category, but it seems likely that a significant proportion of deaths attributed to "illness" could have been prevented by either more efficient emergency care or by more effective preventative care.

Second, this data indicates that a policy aimed towards reducing deaths in state prisons may not be effective for reducing deaths in local jails (and vice versa). Suicide is a much greater concern in local jails than it is in state prisons.[152] Similarly, illness is a much lesser concern in local jails.[153] Consequently, policies aimed at lowering deaths in local jails should put much more focus on preventing suicides.

B. Example Two: Comparing Deaths in Custody Nationwide Across States

Identifying the leading causes of mortality in jails and prisons can

144. Christopher J. Mumola & Margaret E. Noonan, *Deaths in Custody Statistical Tables*, BUREAU OF JUSTICE STATISTICS, 5 (2009), *available at* http://www.bjs.gov/content/dcrp/dcst.pdf.

145. *Id.*

146. *Id.* at 4.

147. *Id.*

148. *Id.*

149. *Id.* at 23.

150. *Id.* at 5.

151. *See id.* at 22–23.

152. *See id.* at 23; *id.* at 5.

153. *Id.*

provide valuable information, but it is far from the only use of DIC data. Nationwide comparison of deaths in custody across states can also be very valuable for at least two reasons: First, it can identify state systems that are over-performing relative to the national average. Such state systems can be used as models for other states that want to improve their prison systems. Second, comparison can identify state systems that are under-performing relative to the national average. These states may be held accountable—particularly by their own policy makers.

As described above, illness is the leading cause of death in state prisons by a wide margin.[154] Consequently, it may be useful to compare state prison systems by relative rates of medical causes of death. Indeed, the Bureau of Justice Statistics has prepared a table that makes such a comparison.[155] In this table, we can see that the national average annual mortality rate for all illnesses is 223 per 100,000 state prison inmates.[156] Most states are fairly close to this rate.[157] The largest deviations come from Louisiana and Vermont. Louisiana boasts the highest illness-related mortality rate at 388 per 100,000,[158] while Vermont has the lowest mortality rate at 108 per 100,000.[159]

These numbers can also be broken down into specific causes of illness-related death. For example, in addition to being the overall leader in illness-related mortality rate, Louisiana has the second highest rate of AIDS-related deaths.[160] While several states have no AIDS-related deaths per 100,000 inmates, Louisiana has 53.[161] This is in contrast to the national average of 18 AIDS-related deaths per 100,000 inmates.[162]

These numbers may not say much on their own, but they can lead to important questions and discoveries. For example, take Louisiana's mortality rates. It is probably not a coincidence that Louisiana prisons have both the highest rate of illness-related deaths and the second highest rate of AIDS-related deaths. AIDS may be a serious problem in certain prison systems within Louisiana. This is not a condemnation on Louisiana. Rather, it indicates that policy makers in Louisiana may need to focus particularly on preventing the spread of AIDS within the state prison populations if they want to lower deaths in custody.

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154. *See id.* at 4.

155. *See* Christopher J. Mumola, *Medical Causes of Death in State Prisons*, BUREAU OF JUSTICE STATISTICS, 9 (2007), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/mcdsp04.pdf.

156. *Id.*

157. *See id.*

158. *Id.*

159. *Id.* It should be noted that from 2001–2004, there were only twelve total illness-related deaths among Vermont state prisoners. *Id.* The rate per 100,000 inmates may be easily skewed in such a small jurisdiction.

160. *Id.* Maryland has the highest rate at fifty-five per 100,000. *Id.*

161. *Id.*

162. *Id.*

C. Example Three: Comparing Deaths in Custody Statewide Across Jurisdictions

The process for comparing deaths in custody statewide across jurisdictions should function much like comparing nationwide across states. Just to illustrate the point, however, I look to suicide rates in the six largest jail jurisdictions within one of the nation's largest states: Texas.

Among the six largest jurisdictions in Texas, we see a very uniform number and rate of jail suicides.[163] In fact, the two largest jurisdictions in Texas—Harris and Dallas Counties—reported an identical number of suicides from 2001–2002 at seven each.[164] The remaining jurisdictions—Bexar, Tarrant, Travis, and El Paso Counties—reported two suicides each.[165] This is somewhat surprising, considering that the overall mortality rate for these jurisdictions varied substantially: from 92 per 100,000 inmates in Tarrant County, to 243 per 100,000 inmates in Harris County.[166] This may indicate a relatively successful statewide approach to curbing suicide rates in Texas.[167]

VI. Conclusion

None of the proposals suggested above are intended to be a cure-all for a corrections system that needs much improvement nationwide. Rather, this is a proposal to utilize information we *already have* in a cost-effective way that encourages accountability and transparency in our nation's prisons and jails. To do so would take a significant step toward improving the functioning of the criminal justice system. Current prison and jail administration policies (particularly in the face of budget concerns) can be viewed as too litigation focused—for example, avoiding liability under the Eighth Amendment. It would be a great help to encourage a more proactive system, where officials actively work toward improving the system rather than wait to react when things get out of hand. We should never forget that governments have an absolute obligation to meet the basic needs of individuals in their custody. Reasonable minds may differ over what constitutes acceptable conditions of confinement—even what constitutes a "basic need"—but it should be beyond dispute that governments have a per se obligation to minimize preventable deaths in custody as best they can. Deaths in custody data allows us not only to see *whether* something is fundamentally wrong with jurisdictional or nationwide conditions of

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163. Christopher J. Mumola, *Suicide and Homicide in State Prisons and Local Jails*, BUREAU OF JUSTICE STATISTICS, 4 (2005), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/shsplj.pdf.

164. *Id.*

165. *Id.*

166. *Id.*

167. This hypothesis is somewhat corroborated by looking at nationwide data. The state of Texas reports 17 suicides per 100,000 jail inmates—a number only marginally higher than the national average at 14. *See id.* at 3.

confinement, but it also helps us determine *what* is wrong. The data is valuable, it is available, and it is our duty to make full use of it.