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*We provide data-driven, proactive solutions to improve corrections and criminal justice outcomes. By collaborating with leaders, we address the root causes of incarceration and staffing challenges while creating opportunities for success in communities.*

# IN-CUSTODY MORTALITY: CHALLENGES, DATA, AND SOLUTIONS

ANALYZING REPORTING GAPS AND POLICY  
IMPLICATIONS

# VALUES AT THE CORE OF INVESTIGATIONS

- In any democracy, limiting an individual's freedom is sobering and serious.
- We have a responsibility to the deceased individual, his or her family and to society, at large. Meaningful death investigations must be:
  - Independent, Objective and Fair
  - Accurate and Timely
  - Focused on addressing immediate cause(s) AND broader systemic patterns
- Responsible correctional leaders embrace independent and objective reviews as a cornerstone of effective management and continuous improvement.
- Investigations can and should ensure accountability and strengthen trust.



# DEATHS IN CUSTODY REPORTING PROGRAM (DCRP)

- Governed by the Deaths in Custody Reporting Act (DCRA)
- Requires quarterly reporting to the Bureau of Justice Assistance by state and local agencies
- State Administering Agencies (SAAs) are responsible for overseeing the process for state and local entities
- Noncompliance can result in penalties, including but not limited to a reduction in federal funds allocated to the state.



# HOW IT SHOULD WORK

- National Commission on Correctional Healthcare (NCCHC) offers a proper blueprint for investigations:
  1. Correctional agency administrative review
  2. Independent criminal investigation
  3. Clinical mortality review
  4. Psychological autopsy
- Important to track critical details in a log that captures key facts of the in-custody death, what occurred, and when each review was completed.



# CURRENT CHALLENGES

- Deaths appear to be increasing as staffing decreases
- Apathy surrounding in-custody deaths
- Political environment often results in blame for the director or agency head
- Requirements of the DCRP reporting may be more burdensome than useful
- DCRP reporting form is not well-designed to capture meaningful details in the data



# TYING EVIDENCE TO PRACTICE: IN- CUSTODY DEATHS

- National data are not easily available
- Transparency is key to building community relationships and to keeping people safe.
- Families need to understand more about what is happening in our facilities for their own mental wellbeing.
- Centralizing de-identifiable data at the federal level allows state and local agencies to make use of the reporting they routinely provide.
- We have a duty to inform correctional practice using the evidence that illustrates what is occurring and how we can improve operations — Make use of what we know.



# SUGGESTED IMPROVEMENTS TO DCRP REPORTING

- Improved data collection standards
- Improved training for agencies on how to comply with DCRA
- Technical assistance through reputable oversight entity
- Enhanced enforcement mechanisms to ensure reporting is done in a timely and accurate manner
- Independent review processes
- Improved access to publicly available data at the federal level



# PROPOSAL FOR AFTER-ACTION REVIEW

- Following a death:
  - Gather facts, analyze what happened and why, both in execution and strategy.
  - Learn from mistakes (and successes) in order to foster change
  - Share lessons learned
- No Blame: no liability, safe space for candid discussion
- Team Members: non-political; experts and thought-leaders.
- Recommendations: make recommendations public and share with appropriate officials and stakeholders
- Results: better outcomes; increase in public trust
- Models: In PA: Parolee Homicide Review Team; Medicine, Aviation





# SUMMARY

- States need support and oversight to improve the quality of in-custody death reporting.
- Everyone has a stake in improving the safety of our correctional facilities.
- Improving our review processes, data collection, and evidence-based practice is the first step, especially with regard to people dying in custody.



# THANK YOU

**John E. Wetzel**

Founding Board Chair

Keystone Restituere Justice Center

[JohnWetzel@keystonejustice.org](mailto:JohnWetzel@keystonejustice.org)

**Greg Rowe**

Executive Director

Keystone Restituere Justice Center

[growe@keystonejustice.org](mailto:growe@keystonejustice.org)