Welcome to today’s webinar. We’ll begin shortly.

DICRA Data Reporting by SACs: Initial Challenges and Solutions

Presented by
Justice Research and Statistics Association

June 4, 2020
Challenges in DICRA Data Collection & Reporting

Criminal Justice Coordinating Council
Main Challenges for Reporting

- Identifying potential reporting agencies and fostering relationships across agencies
- Strategies for data collection and tool development
- Confirming non-reporting and data quality
Identifying Agencies and Fostering Relationships
Georgia Deaths Investigation Act (O.C.G.A. 45-16-20)

“requires that the coroner or the county medical examiner where the body was found or the death occurred be notified and that a medical examiner’s inquiry be made.”
Strategies for Data Collection Development and Tool
CHALLENGES:

- Getting into contact and fostering relationships with Medical Examiner Offices
- Obtaining data on a monthly basis

PROCESS:

- Obtaining contact information for identified agencies
- Meanwhile, developing a data collection tool with assistance from GDC
- Set up secure server to store data
Confirming Zeroes and Data Quality
Challenges in Confirming Zeroes

- Currently do not have a system in place to reach all reportable agencies
- Pursuing MOU with DPH for death certificates, but experiencing serious delays
- Considered sending out a survey to confirm zeroes, but do not have the staff, time, or contacts to reach out to over 600 LE agencies

Data Quality

- Since we cannot fully confirm all zeros, we may be missing some county deaths
- Current reporting guidelines excluding potential cases, especially those involving Co-VID19
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Deaths in Custody Reporting in Kentucky
Data Collection Strategy

- Direct reports are received using an established process from:
  - Kentucky Department of Corrections,
  - local jails,
  - Kentucky Department of Juvenile Justice,
  - local coroners,
  - and Office of the State Medical Examiner.
- CJSAC staff conduct supplemental media searches to identify deaths that occur during law enforcement contact, but prior to being booked into a facility.
The specifics

- Use administrative funding from the Edward R. Byrne Justice Assistance Grant program to fund staff time for the data collection efforts and reporting.
- We are considering adding a special condition specific to this reporting to our grant awards to ensure maximum compliance; however, not all entities receive grant funds.
Accessing Information for the Report

- Receive no-fee official copies of death certificates for identified individuals from the Kentucky Department of Vital Statistics
- Have access to the Kentucky Offender Management System via an agreement with the KY DOC
- Receive Extraordinary Occurrence Reports (EOR) and other supporting information from KY DOC
- Media Accounts and other public records
- Receive results of toxicology and other relevant information from OSME/Coroners
- Follow up with relevant law enforcement agencies when necessary
Caveats for Kentucky

- Overdose-related deaths where law enforcement is on scene
- Local Jails (agreement with KY DOC stipulates that all deaths of state or local inmates must be reported to Kentucky DOC’s Department for Local Facilities)
- Deaths that are pronounced in a hospital rather than the correctional facility
- Individuals who are “discharged” due to staffing needs (e.g. coma or other illness)
- Mechanism to confirm hard zeroes
- Lack of information about “natural” deaths that occur before booking (e.g. cardiovascular incident, asthma attack, OD, etc.)
Other populations to consider- are we capturing this information?

- Corrections-involved individuals in drug treatment facilities operated by or on behalf of the Kentucky Department of Corrections
- Corrections involved individuals on work release or a similar assignment (e.g. day treatment)
- Persons awaiting transport to other state or federal Department of Corrections facilities
- Deaths in which law enforcement is on scene, but may not have “detained” individual or we are unsure if an arrest would have occurred (e.g. overdoses, motor vehicle crashes, etc.).
Further Steps

- Continue exploring ways to capture data from our “gray area” populations
- Continue and expand partnerships with stakeholders
- Implement special condition re: reporting on grant awards
- Establish a scalable process to confirm hard zeroes
- Explore data in the KY OPS Naloxone Portal
- Continue to educate local law enforcement agencies and coroners about the need for reporting
Deaths in Custody Reporting in Ohio

Lisa Shoaf
SAC Director
Ohio Deaths in Custody Program

- 2003—ARD data collection began
  - 2008—started publishing annual ARD reports

- 2014—BJS suspended ARD data collection
  - Ohio continued to collect data

- 2015—Ohio Community-Police Collaborative began

- 2017—Ohio ARD website and dashboard created

- Fall 2019—Data collection expanded to include all deaths in custody
Current ARD data collection

• No mandate for LE agencies to submit ARDs to OCJS

• How to identify ARDs?
  • Google search on key terms “Officers” “shoot OR kill”
  • Social media reports
  • News clipping service
  • Use of force incidents in NIBRS

• SAA involvement
SAC/SAA Collaboration

- Getting the word out
  - OCJS Newsletter
  - Letter to Ohio Chiefs of Police Association
  - Letter to Buckeye State Sheriff’s Association
  - Letter through Ohio Collaborative
  - Letter via OIBRS portal
- Ohio State Coroner’s Association
SAC/SAA Involvement

Deaths in Custody Reporting

The Ohio Office of Criminal Justice Services (OCCJS) is responsible for collecting data on behalf of the Department of Justice with regard to the federal Deaths in Custody Reporting Act (DCRA) of 2013 (Public Law 113-242). This Act requires the reporting of certain data on deaths of individuals who are 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 correctional facility (including any juvenile facility).

Deaths that occur in the process of an arrest by state and local law enforcement agencies, also known as an arrest-related death (ARD), are also included. An ARD is defined as any death (e.g., gunshot wound, cardiac arrest, or drowning) that occurs during an interaction with state or local law enforcement personnel, including those that occur:

- Shortly after freedom to leave is restricted, all deaths that occur shortly after a person’s freedom to leave is restricted by state or local law enforcement personnel.
- During an attempt to arrest or in the process of arrest, all deaths that occur during the interaction with law enforcement personnel.
- Without any direct action by law enforcement. This would include deaths attributed to suicide, intoxication, accidental injury, medical emergencies or health complications.
- While in custody (before transfer to jail), all deaths that occur after law enforcement have established physical custody of an arrestee. These in-custody deaths can occur at the scene of the incident, during transport or while the suspect is being held at a law enforcement facility.

It should be noted that not all deaths that occur during an interaction with state or local law enforcement personnel are reported to the ARD program, and they include:

Ohio Arrest-Related Deaths

- Arrest-Related Deaths 2018
- Arrest-Related Deaths 2017
- Arrest-Related Deaths 2016
- Arrest-Related Deaths 2015
- Arrest-Related Deaths 2014
- Arrest-Related Deaths 2013
- Arrest-Related Deaths 2012
- Arrest-Related Deaths 2011
- Arrest-Related Deaths 2008-2010

Report a Death in Custody Form
PDF | Word
SAC/DRC Collaboration

- Department of Rehabilitation and Correction
  - In charge of 28 state prisons
  - Bureau of Adult Detention
  - Bureau of Community Sanctions

- Collaboration began August 2019
  - Vetted by DRC legal
  - All info provided considered “public”
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<th>Parent Institution</th>
<th>Inmate Name</th>
<th>Inmate Number</th>
<th>Gender</th>
<th>Race</th>
<th>Ethnicity</th>
<th>Birth Year</th>
<th>ODRC Admission</th>
<th>Date of Death</th>
<th>Time of Death</th>
<th>Location of Death</th>
<th>Manner of Death</th>
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<td>Hispanic,</td>
<td>1950</td>
<td>1997-10-08</td>
<td>2020-01-02</td>
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<td>A555325</td>
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<td>1931</td>
<td>1993-12-10</td>
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<td>2010-10-16</td>
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<td>SCI</td>
<td>Brandor</td>
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<td>1963</td>
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Please provide a brief description of the circumstances leading to the death (e.g., details surrounding an event that may have led to the death, the number and affiliation of any parties involved in an incident, the location and characteristics of an incident):

Transported patient to local ER where he was pronounced dead at 6:41 pm. Death Certificate: HEART INCIDENT

On January 6, 2020 at 4:47 p.m. inmate Gene Mullins A555-325 passed away at the Ohio State University Hospital due to Metastatic pancreatic Cancer.

Offender Welstead A-286276 passed away on Wednesday, January 15, 2020 at 9:13am, at Mount Carmel Hospital (Grove City) due to Cardiac Arrest. The cause of death is Medically unexplained.

Offender Smith A-671150 passed away on Friday, January 17, 2020 at 2:14 pm, at the Ohio State University Hospital due to Colon cancer and sepsis.

Inmate Warren Spivey #A216-212, died Friday, January 17, 2020, at 10:13 am, at the Adena Regional Medical Center. The cause of death is medically unexplained.

Offender Jeremy Sanchez A-766907 passed away on Sunday, January 19, 2020, at 9:54 pm at the Ohio State University Hospital due to Cardio Pulmonary Arrest.

Brandon Nutt A746775 passed away at the ER of Fairfield Medical Center this morning at 8:19am. Preliminary cause of death is pending until the outcome of the autopsy.

Offender Szorady A-582893, passed away on Wednesday, January 22, 2020 at 12:33 am, at Franklin Medical Center, Zone A due to Liver Cancer.

Offender Geoffrey Pearl A-764067 passed away on Sunday, January 26, 2020 at 12:07 am, at Franklin Medical Center Zone A, due to a LMCA Stroke.
Where are we now?

• We still struggle to obtain ARD data. We proactively identify nearly all ARDs and reach out to coroners for confirmation. We have limited involvement of LE unless we need information that the coroner cannot provide.

• We are successfully collecting information from all prisons, jails, and community based correctional facilities. We are also collecting information on juvenile facilities.

• We do not collect ‘confirmatory No’ responses from our partners, and we have no way of doing so.
Questions?

Lisa Shoaf, SAC director
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Virginia Deaths in Custody Reporting Process

June 2020
Potential DCRA Reporting Agencies in Virginia

The SAC identified a total of nearly 500 potential DCRA reporting agencies or facilities in Virginia

Law Enforcement
- 240 police departments
- 122 sheriff’s offices

Jails
- 36 local jails
- 22 regional jails
Potential DCRA Reporting Agencies in Virginia

Virginia Department of Corrections
- 26 major institutions
- 8 field units
- 6 work centers
- 1 private prison
- 2 secure hospital units

Virginia Department of Juvenile Justice
- 24 Juvenile Detention Centers (local-responsible)
- 1 Juvenile Correctional Center (state-responsible)
- Other local, nonsecure residential placement facilities
SAA Convened Meeting of Potential Reporting Agency Representatives to Discuss DCRA

- VA Association of Chiefs of Police
- VA Sheriff’s Association
- VA State Police
- VA Association of Regional Jails
- VA Department of Corrections
- VA Department of Juvenile Justice
- Office of the Chief Medical Examiner
Reporting Concerns Identified by Agencies

- Staff time required to collect and report data
- Duplication of existing reporting requirements
- Release of personal identifying information
- Lack of clear definition of what constitutes a reportable death
- Who reports deaths when multiple agencies involved in a death incident
- Potential public reporting of data that identifies agencies by name
Reporting Concerns Identified by the SAA

- Staff time required to collect and report data
- Release of personal identifying information
- Lack of clear definition of what constitutes a reportable death
- Keeping up with contacts turnover in 500 potential reporting agencies
- Obtaining “affirmative no” response from nearly 500 potential reporting agencies, every quarter
Reporting Strategy Identified by SAA

Office of the Chief Medical Examiner (OCME) in the VA Department of Health has centralized death reports

Code of Virginia § 32.1-283. Investigation of deaths; obtaining consent to removal of organs, etc.; fees.

A. Upon the death of any person ..... in jail, prison, other correctional institution or in police custody.... the Office of the Chief Medical Examiner shall be notified by the physician in attendance, hospital, law-enforcement officer, funeral director, or any other person having knowledge of such death.....

B. Upon being notified of a death .... the Chief Medical Examiner shall cause an investigation into the cause and manner of death to be made and a full report .... to be prepared.
OCME and SAC Created Data Sharing Memorandum of Understanding

The MOU specified that SAC would:

- Use secure transmission process to receive electronic files from OCME
- Use the OCME data only for reporting to BJS
- Maintain data securely
- Maintain data only for as long as needed for reporting to BJA, and then destroy it
- Limit access to data to two SAC staff, and one person in DCJS grants management section who enters data into the GMS PMT for upload to BJA
Tested Data Transmission and Utility for DCRA Reporting

Prior to starting formal DCRA reporting, OCME and SAC exchanged an electronic file (Excel) containing relevant death reports data for the three months prior to the first quarterly period required by the BJA reporting (i.e., first required reporting quarter was deaths in October – December of 2019, so we tested using deaths data for July – September of 2019).

Test showed that secure data transmission worked and that SAC received the data we needed for reporting to BJS.
First Formal DCRA Data Reporting

• SAC received first OCME file for reporting to BJA, covering deaths from October - December of 2019, in early April 2020.

• File contained 32 reportable cases. Only one was an arrest-related death; the remainder were deaths in correctional custody.

• SAC reviewed data file for completeness, then sent to the SAA’s Grants Admin section to transmit to BJA.

• Transmission from SAA to BJS was successful.
Outstanding Issues

- Determining if OCME reporting actually covers all reportable deaths under DCRA.
- Based on reviews of media reports, we think there may be arrest-related deaths missed by the OCME reports.
- Previous experience with deaths in custody reporting program in the early 2000s, the need for such follow-up is not uncommon.
- OCME report does not include date deceased person was admitted to a correctional facility, which is required by DCRA.