In-Custody Deaths in Ten Maryland Detention Centers, 2008-2019

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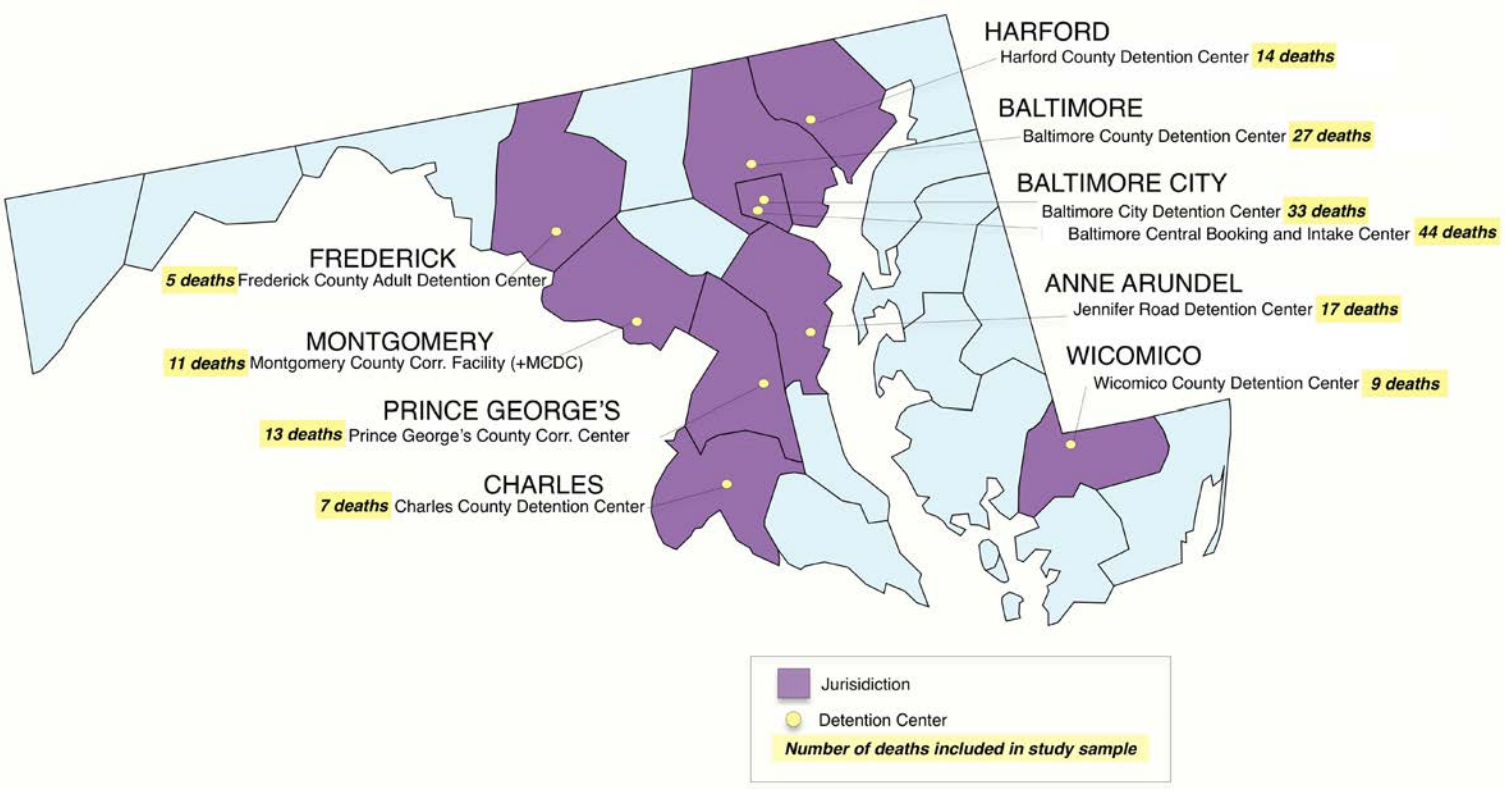

The BioCritical Studies Lab

After Release

HELPING OURSELVES TO TRANSFORM
EDUCATING AND PROMOTING MASS LIBERATION

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Executive Summary

The BioCritical Studies Lab analyzed a sample of 180 deaths in 10 city and county detention centers in Maryland between 2008 and 2019. These detention centers are distinct from state correctional facilities in that they primarily confine persons who are awaiting trial or arraignment. Our study sample reflects only deaths self-reported by these 10 city and county detention centers to the Bureau of Justice Statistics (BJS) during this time period. Our sample represents only a portion of all in-custody deaths known to have taken place throughout Maryland during the study period.

Our analysis produced five key findings:

- First, the detention centers with the most instances of in-custody death in our study sample are situated in jurisdictions with both high rates of poverty and large numbers of Black residents. The confluence of these two factors is strongly correlated to in-custody death.

- Second, the average age of in-custody deaths officially designated as "natural" is substantially lower than life expectancy among the non-jailed population, possibly indicating the widespread misclassification of deaths attributable to violence and/or negligence as "natural" by the Maryland Office of the Chief Medical Examiner.

- Third, over 80% of the deaths in our sample took place while the decedent was awaiting trial, meaning they had not been convicted of any crime at the time of death.

- Fourth, about half of the decedents included in our sample died within 10 days of their admission to the detention center, while more than one sixth died within a single day, suggesting that even short stays in detention present a significant risk of premature death.

- And fifth, there currently exist high barriers preventing public access to key information regarding deaths in Maryland detention centers that place comprehensive study of this social problem out of reach.

We conclude by making several recommendations as to how policymakers might address the problems described in this report, including systematically reducing jail populations through the elimination of pretrial detention, establishing an explicit mandate for the Office of the Chief Medical Examiner to investigate all instances of in-custody death, and codifying new standards for publicly reporting information about in-custody deaths when they occur.

Background

Across the United States, encounters with law enforcement are reliably correlated with adverse health outcomes and elevated rates of premature death, especially for people of color, members of low-income communities, and unhoused individuals. National data provides statistical evidence of the crisis: Black Americans are 3.5 times more likely to be killed by law enforcement than their white counterparts, and nearly 60 percent of police-involved deaths of Black Americans went unreported to federal authorities between 1980 and 2019.[1] A series of widely publicized police killings between 2015 and 2020 stoked a nationwide protest movement calling for the defunding of local police departments, investments in community-based and non-carceral solutions to violence and harm, and a permanent end to deaths during arrests. While this movement has brought substantial attention to the crisis of fatal police encounters on the streets of U.S. cities, a similarly dire crisis of premature death inside jails and prisons has received comparatively less attention.

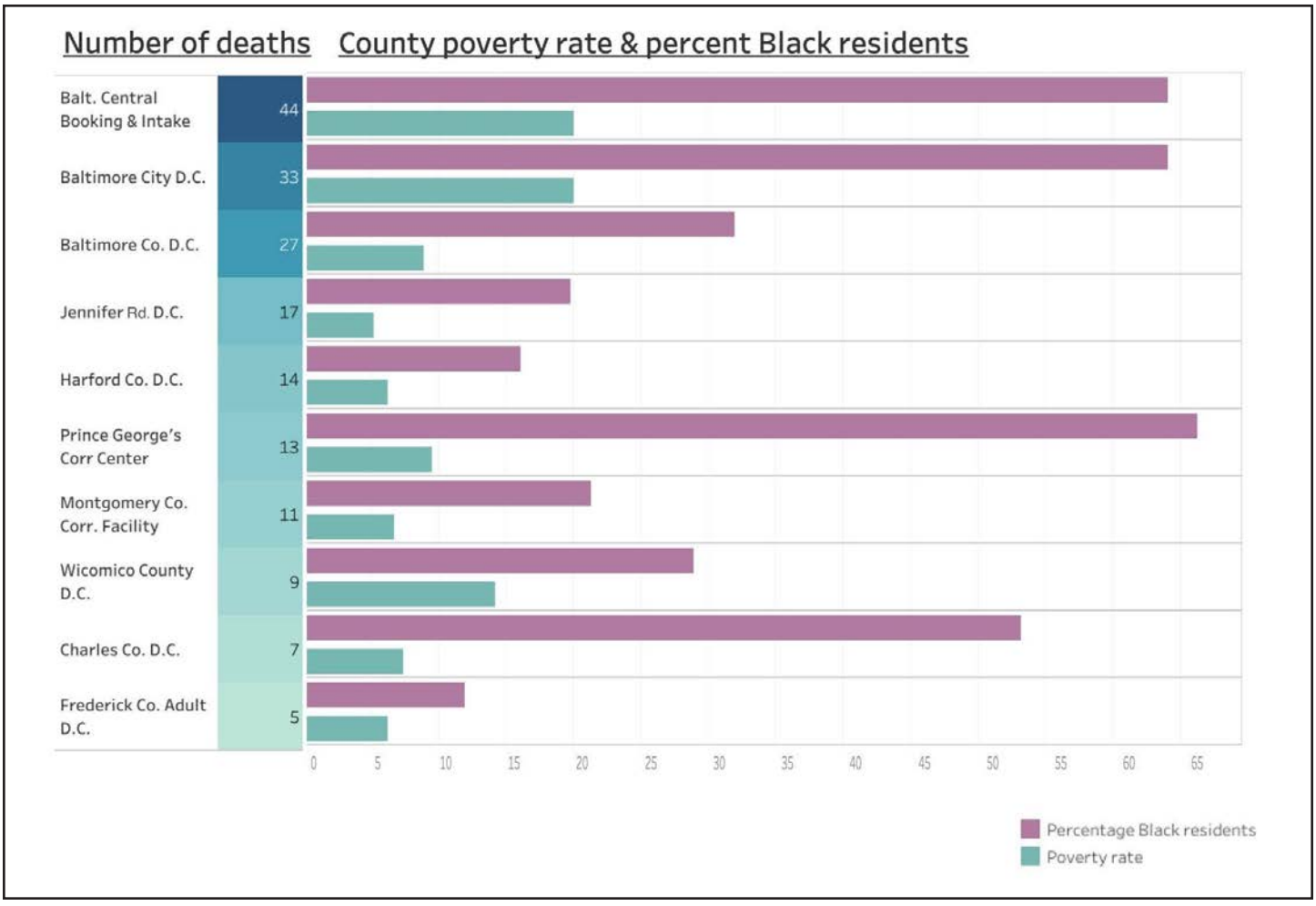
The BioCritical Studies (BCS) Lab, founded and directed by Dr. Terence Keel of the University of California–Los Angeles, has been studying the crisis of in-custody death in counties across the United States since 2020. Using a wide range of publicly available data, the BCS Lab works to identify evidence of law enforcement violence and medical negligence in in-custody death cases, not only by analyzing aggregate data as in this report but also by evaluating autopsy and toxicology records produced by coroners and medical examiners.

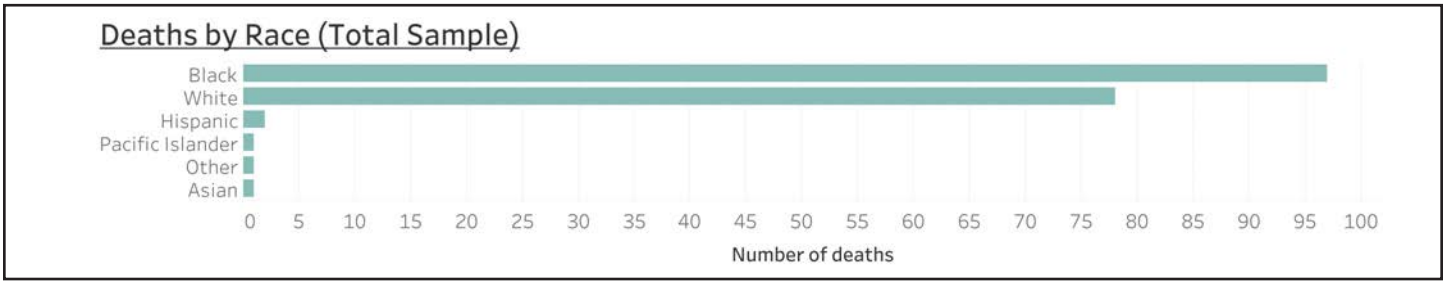
This report resulted from a collaboration between multiple organizations committed to criminal justice reform, including DMV-based non-profits Helping Ourselves to Transform (HOTT) and Life After Release (LAR), as well as Civil Rights Corps (CRC), a national organization based in Washington, DC. LAR, led by formerly incarcerated Black women, is dedicated to organizing directly impacted people with the goal of exposing and dismantling the criminal punishment system. HOTT is dedicated to building bridges between newly released loved-ones and their communities, including businesses and elected officials, to move us closer to a cure for mass incarceration that brings mass liberation. CRC is a non-profit law firm that works in close partnership with impacted communities and grassroots organizations to use litigation, policy, and narrative storytelling in support of abolitionist visions for the future. Together these groups worked with the BCS Lab to examine deaths in local detention centers, state prisons, and during street encounters with police in Maryland. And Zealous is a national advocacy and education initiative that harnesses the power of media, technology, storytelling, and the arts to topple the imbalance of power over criminal justice media and policy. This report, focusing on in-custody deaths in local detention centers, is the first product of that research collaboration.

1 Romero, Maybell. "Law Enforcement As Disease Vector." SSRN Scholarly Paper. Rochester, NY, October 11, 2020. https://papers.ssrn.com/abstract=3617367.

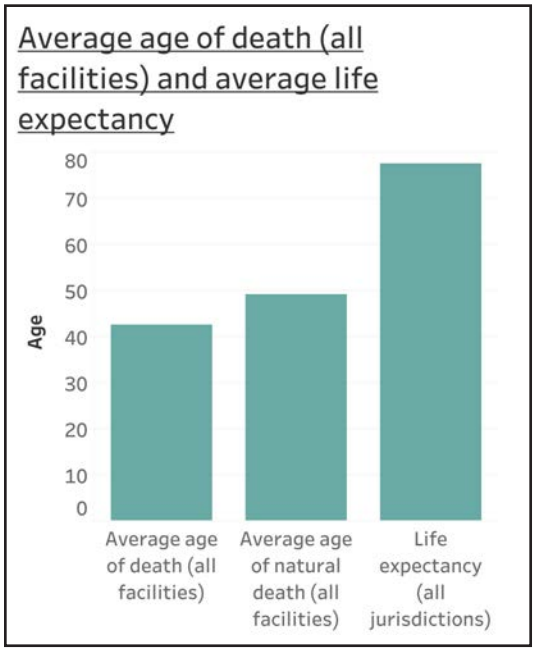
Major Findings

1. The detention centers with the most instances of in-custody death in our study sample are situated in jurisdictions with both high rates of poverty and large numbers of Black residents.*



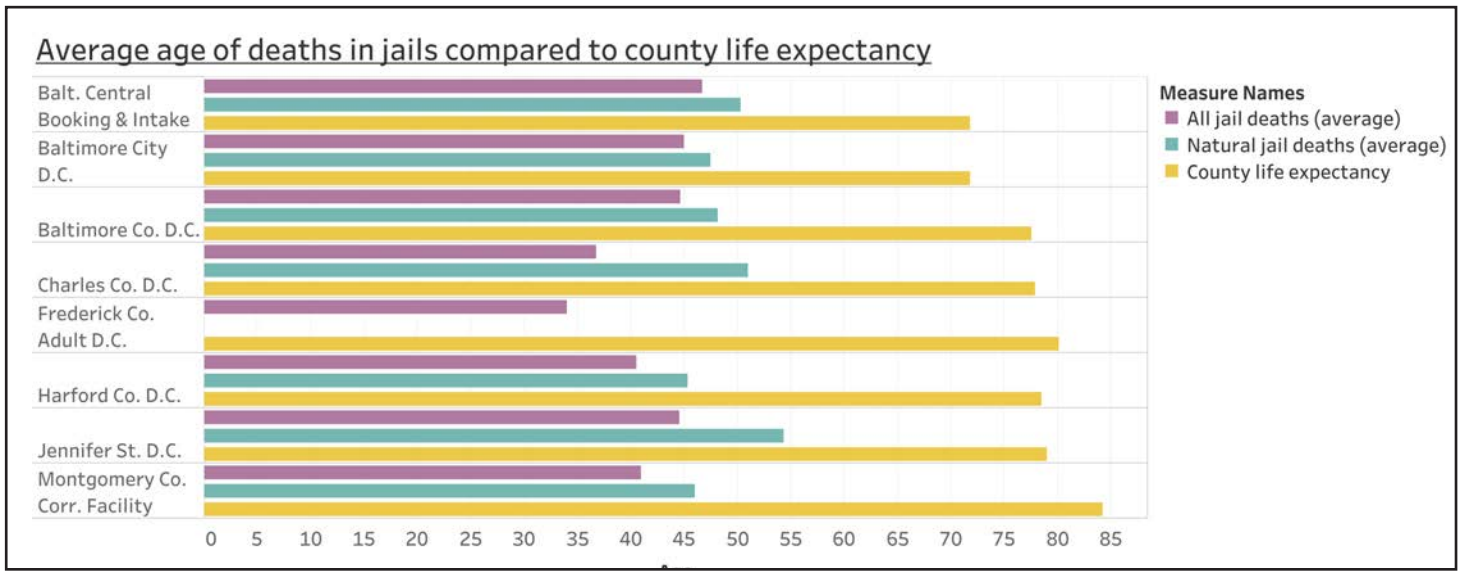


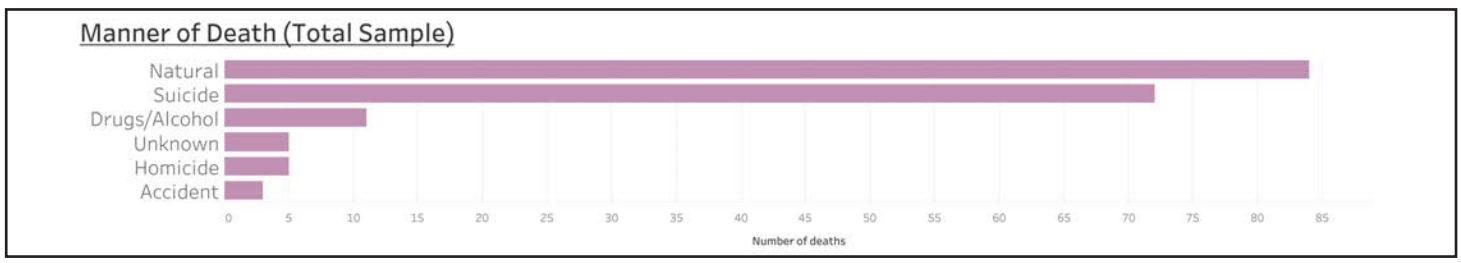
2. In every detention center,** the average age of in-custody death was substantially lower than the average life expectancy in that city or county, as determined by the Maryland Department of Health.***



The average age for all deaths in our study sample is 43.6 years, which is 33 years younger than the average life expectancy for the non-jailed population in Maryland (77.3 years).

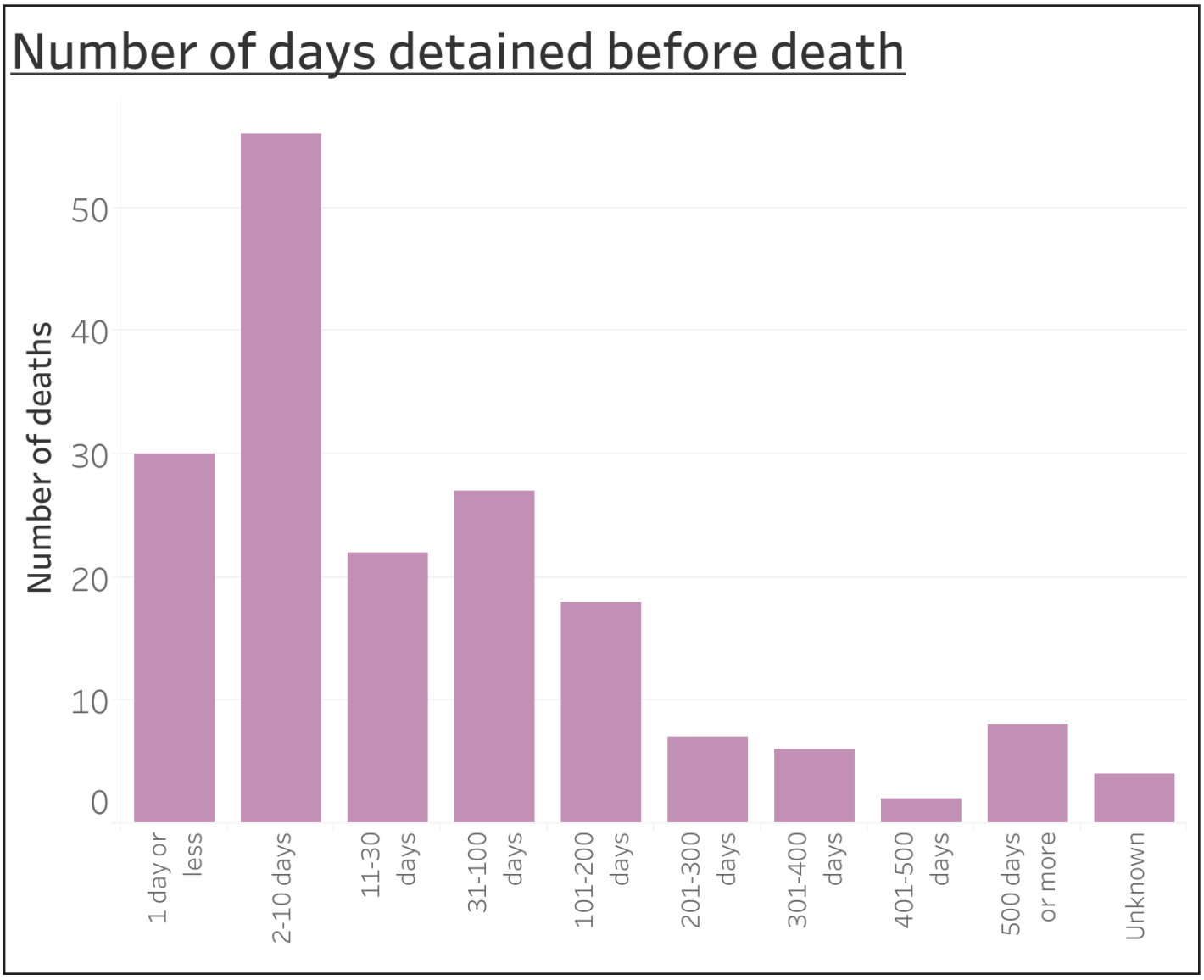
The average age for "natural" deaths in our study was 49.2 years, which is 28 years younger than the average life expectancy for the non-jailed population in Maryland.





3. Four out of five decedents in our study sample (85.39%) were detained pretrial at the time of their death, meaning they had not been convicted of any crime.

4. Almost half of the decedents in our study sample (47.78%) died within 10 days of their admission to the detention center. More than one in six (16.67%) died within one day.



5. The number of in-custody deaths contained in our sample is much lower than the numbers estimated by legal advocates and community organizations based on other sources of data. The scope of this discrepancy suggests that Maryland detention centers may tend to underreport in-custody deaths to higher authorities such as the U.S. Bureau of Justice Assistance.

Public understanding of in-custody deaths has been substantially limited by insufficient reporting practices and inconsistent record keeping. Our review of additional sources of data obtained by community partners through Public Records Act requests suggests that our sample represents a small portion of all in-custody deaths in Maryland during the study period.

In addition to our 180-decedent sample derived from the BJS data, the BCS lab also consulted a dataset titled "Maryland Deaths in Custody 2003-2020," obtained via PIA request and provided to us by community partners. This spreadsheet includes the names and demographic information of 1,313 decedents (832 decedents during our time period of interest), but does not report on the setting of death (street or carceral). The BCS Lab was able to identify the location of some of these deaths by cross-checking with the other databases utilized in this report. The BCS Lab also combined the "Maryland Deaths in Custody 2003-2020" dataset with an internal dataset maintained by the Lab, called the List of Lost Lives, that combines data compiled by the news organization Reuters with data compiled by the non-profit organization Fatal Encounters. Using the List of Lost Lives, the BCS Lab identified 91 names of individuals who died in the custody of law enforcement on the streets of Maryland between 2008 and 2019. Of these 91 names, 66 were not found in any other database. Full names were included for only 50 of the 180 individuals contained in the BJS dataset that comprise our sample, thus making it extremely difficult to cross-check identifying variables with other datasets.

A complete review of all datasets in our collection suggests that there were at least 1,078 in-custody deaths in Maryland during the 2008-2019 study period. After accounting for the 91 confirmed street deaths and 180 confirmed jail deaths, we estimate that there remain at least 807 in-custody deaths reflected in our overall data for which we cannot determine a setting (i.e. street, jail, or prison).

The insufficiency of available data demonstrates that in-custody deaths are inconsistently documented by officials at multiple levels of government. This makes it incredibly difficult to identify risk factors for death during detention or interaction with law enforcement, which in turn inhibits accountability, community input regarding solutions, political intervention by elected officials, and social change. Enhancing internal and public reporting requirements related to in-custody deaths is a necessary but insufficient first step to addressing the present crisis of in-custody deaths in the short term. Indeed, it is the bare minimum Maryland residents deserve. We conclude that far more transparency is required to ensure adequate community participation in policy reforms and also to meet the minimum standards of public accountability established by Maryland and federal statutes.

Methods

To complete this report, the BCS Lab created a research sample (n=180) using information from the Bureau of Justice Statistics' (BJS) "Mortality in Correctional Institutions" dataset. Our research sample contained specific demographic, circumstantial, and personally identifying information for 180 decedents who died between 2008 and 2019 in 10 Maryland detention centers. We partially anonymized this data by omitting names but preserving the race, gender, age, date of admission, date of death, location of death, cause of death, and manner of death for each decedent. From this data, we expanded all abbreviated data points and labeled all missing data points as "Unavailable." We standardized all categories under each variable. To determine age, we used Google Sheets' "DATEDIF" function, which calculates the number of days, months, or years between two dates. For our purposes, the function calculated the number of years between the date of birth and the date of death of each decedent, both of which were generally included in the BJS dataset.

We then produced visualizations related to a number of key variables for each detention center and for the research sample as a whole, specifically: 1) racial demography of decedents; 2) age and manner of death; 3) portion of decedents convicted/unconvicted; and 4) length of detention prior to death. We also identified the most commonly occurring natural and non-natural causes of death in each detention center included in our research sample. Finally, we compared the results of this analysis with several variables related to the overall (i.e. non-jail population) demographics of the jurisdiction in which each detention center is located, using data from the Maryland Department of Health's "Maryland Vital Statistics Report, 2020" and the U.S. Census. These variables include racial population demographics in each county, life expectancy in each county, and relative rates of poverty in each county.

Limitations of the Study

The information analyzed in this study is limited to data self-reported by individual detention centers to the Bureau of Justice Statistics between 2008 and 2019 and included in the BJS's "Mortality in Correctional Institutions" dataset. The quality of these data varied greatly between detention centers. Two detention centers included in our sample failed to provide data suited to calculating age. Four detention centers in our sample failed to report cause of death data adequate to inclusion in this report. Individual data points related to age, date of admission, and trial status were omitted by three detention centers in our sample.

Furthermore, the cause of death data that is included varies substantially in quality, with some detention centers reporting formal pathological diagnoses (i.e. "Atherosclerotic Cardiovascular Disease") and others reporting only vague and/or euphemistic causes (i.e., "cardiac issues"). For this reason, it is impossible to determine with a high degree of confidence any patterns related to cause of death from the data provided. Such an analysis would require detailed review of the autopsy and toxicology reports produced in each case by the Maryland Office of the Chief Medical Examiner, which are currently unavailable to the researchers.

Finally, we were constrained by the lack of usable data from the most recent three-year period (2020-2022). For this reason, our study can capture trends only as they existed prior to the end of 2019. However, we have seen nothing to suggest that these trends have improved following the study period. In fact, in-custody deaths increased nationwide between 2020 and the present, a period that saw the onset of a global pandemic that ravaged in-custody populations and Black communities more broadly.

The present study is relevant to what we regard as a current and ongoing crisis of premature death in Maryland detention centers. Our efforts to obtain data for the 2020-2022 period are ongoing and may be analyzed in future reports.

Conclusions & Recommendations

Conclusion:

Even very short periods of detention pose significant risks of premature death to persons who are detained.

In-custody death in Maryland detention centers represents a grave human rights crisis that requires immediate political intervention. The overriding policy goal must be to reduce the overall number of people admitted to detention centers across the board. Police, commissioners, judges, and pretrial services agents all must exercise a much greater degree of restraint when deciding whether to place someone under arrest or to detain someone pretrial.

Recommendation:

Legislation, executive order, and/or court rules greatly narrowing the scope of charges that can give rise to pre-trial detention.

All reforms should be oriented towards maximizing the total number of people released after arrest on their own recognizance, meaning that they are released without conditions on the basis of their promise to appear for court.

Policymakers should limit the type of charges that are eligible for detention. Narrowing the detention net must be accomplished without a corresponding expansion in the use of electronic monitoring and/or home confinement.

Conclusion:

The Maryland Office of the Chief Medical Examiner (OCME) may tend to misclassify in-custody deaths attributable to violence and/or neglect as "natural."

We reach this conclusion based on: 1) discrepancies between general life expectancy and age of in-custody deaths designated as natural; and 2) short durations between initial detention and death. This tendency fits a pattern that the BCS Lab has documented elsewhere in the United States, notably in the Los Angeles Office of the Chief Medical Examiner.

Recommendation:

Legislation requiring the Maryland Office of the Chief Medical Examiner to conduct full investigations, including autopsy, for all in-custody deaths. Such legislation may require that the OCME convene public inquests for the purpose of determining cause and manner of death in all in-custody death cases.

The statute establishing the Maryland Office of the Chief Medical Examiner (Md. Code Ann., Health–Gen. § 5-305) includes no mandate that all in-custody deaths be investigated by the OCME. In this respect, Maryland is unique among its neighbors. Similar statutes in Delaware, Pennsylvania, Virginia, Washington, D.C., and West Virginia each mandate that coroners and/or medical examiners investigate all incidents of in-custody death.

As currently constituted, Maryland law contains sufficient ambiguity to functionally grant sheriffs, police, and other law enforcement officials the discretion to determine whether an in-custody death constitutes a medical examiner's case, and therefore whether it must be reported to the OCME (Md. Code Regs. 10.35.01.18). Maryland law also grants the OCME the discretion to determine, based on subjective criteria, whether an in-custody death reported to its office requires investigation and autopsy (Md. Code Regs. 10.35.01.18). This ambiguity and resulting discretion must be corrected and new rules established to unambiguously require full investigation of all in-custody deaths by the OCME.

The existing pathways through which qualified members of the public may appeal cause and manner of death determinations (Md. Code Regs. 10.35.01.13) are insufficient in cases of in-custody death.

Conclusion:

Officials have established unreasonably high barriers to public access of key information regarding in-custody deaths.

The stipulation that an OCME investigation report "constitutes an individual file of the Chief Medical Examiner not subject to disclosure" (Md. Code Regs. 10.35.01.18-4) greatly reduces transparency in in-custody death cases. This rule is contrary to the public interest in that it places comprehensive study of in-custody death out of reach, especially for community advocates. This lack of transparency also makes it virtually impossible for affected communities to hold officials accountable in individual cases of in-custody death.

Recommendation:

Legislation establishing a public reporting requirement for all cases of in-custody death, possibly including mandatory public inquests and/or indication of in-custody status on the public death certificate.

Such legislation would be consistent with existing laws in other jurisdictions. In California, for example, a law passed in 2022 (CA AB 2761) mandates that death certificates indicate that a decedent died in-custody subsequent to police use of force. This law further mandates that relevant authorities publicly release key information within 10 days of each in-custody death.

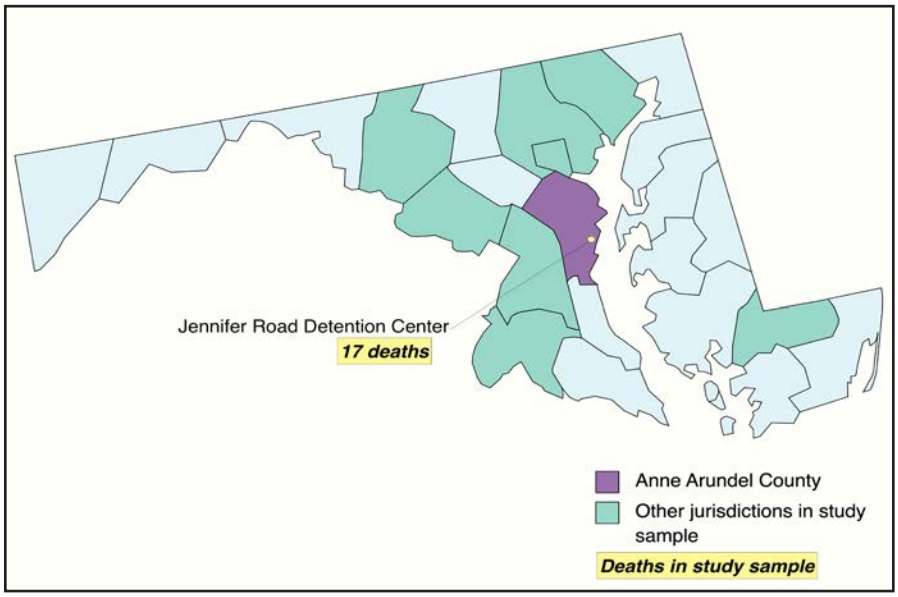
NOTES

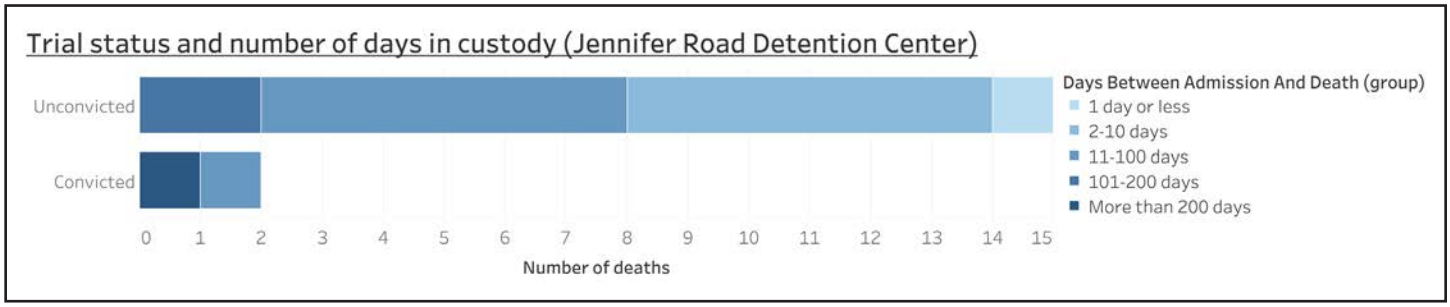
* Baltimore City Detention Center was permanenty closed in 2015. All deaths in our study sample occuring in that facility took place between 2008 and 2015.
** Our data set did not contain adequate information to calculate average age of death in Prince George's County Correctional Center or in Wicomico County Detention Center. These two facilities are ommitted from major finding #2.
*** This remained true even when in-custody deaths officially designated as accidents, drug overdoses, homicides, and suicides were omitted and when controlling for race and gender.

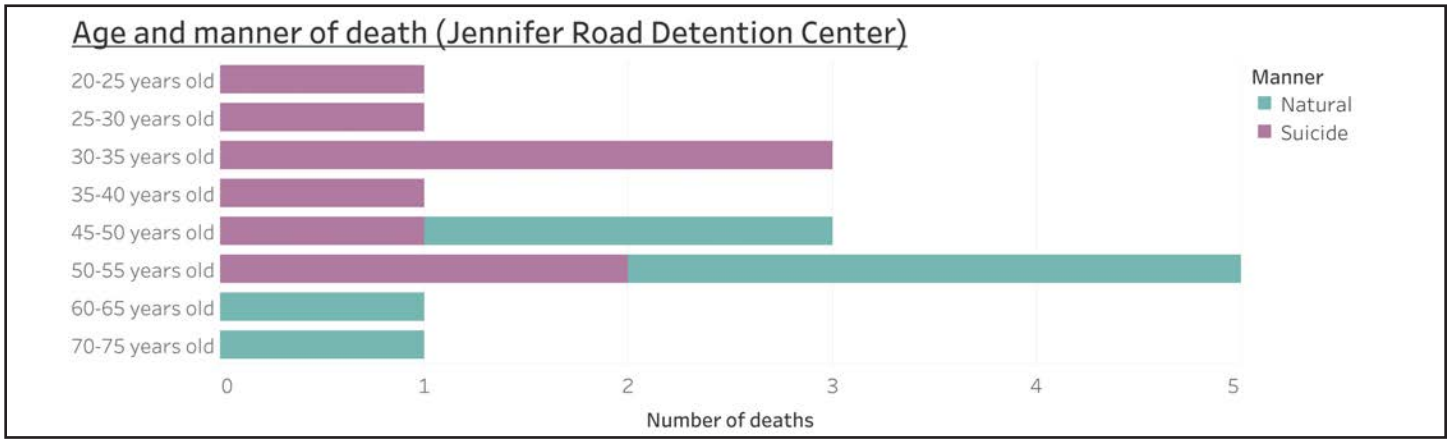
Appendix:
Fine-Grained Analysis by Facility

Jennifer Road Detention Center (Anne Arundel County)

Our sample contained a total of 17 deaths in Jennifer Road Detention Center (Anne Arundel County). Of these decedents, 4 were identified as Black men, 10 as white men, 1 as a Black woman, and 1 as a man of unspecified ("other") race. The most common manner of death was suicide (n=10), followed by natural (n=7). The overall most common cause of death was hanging (n=10), while the most common cause of natural death was atherosclerotic cardiovascular disease (n=2). The average age for all deaths was 44.56 years (n=16; one age unknown), while the average age for natural deaths was 54.29 years. The median length of stay in the detention center prior to death was 15 days (min: 0 days; max: 416 days). 88.24 percent of decedents (n=15) were unconvicted/awaiting trial at the time of death.



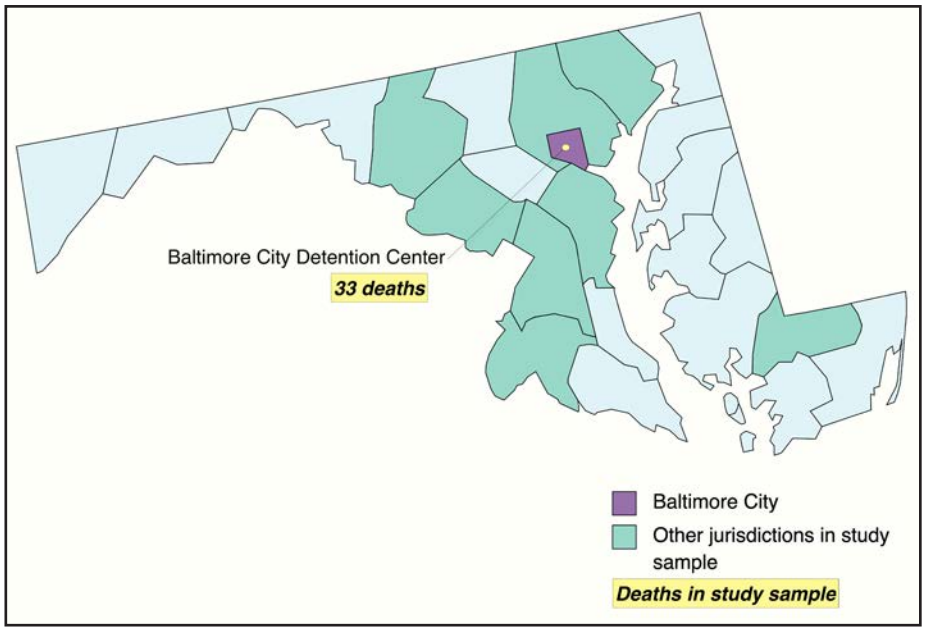


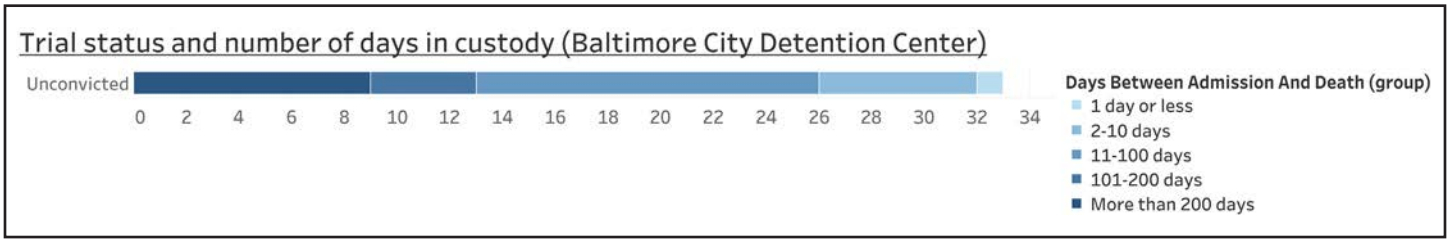


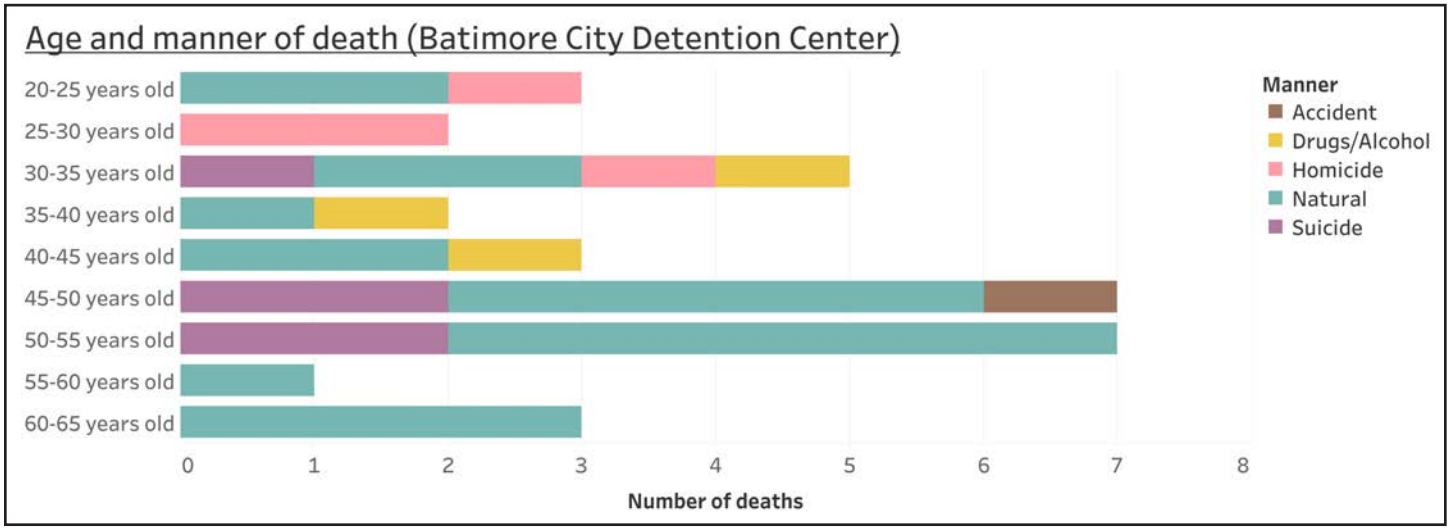
Baltimore City Detention Center

Baltimore City Detention Center was permanently closed in 2015. All deaths in our study sample occuring in that facility took place between 2008 and 2015.

Our sample contained a total of 33 deaths in Baltimore City Detention Center.* Of these decedents, 20 were identified as Black men, 5 as white men, 5 as Black women, and 3 as white women. The most common manner of death was natural (n=20), followed by suicide (n=5), homicide (n=4), drugs/alcohol (n=3), and accident (n=1). The overall most common cause of death was asphyxia-hanging (n=5), while the most common causes of natural death were all related to cardiac distress (n=8). The average age for all deaths was 42.94 years, while the average age for natural deaths was 46.1 years. The median length of stay in the detention center prior to death was 70 days (min: 0 days; max: 925 days). All decedents (100 percent; n=33) were unconvicted/awaiting trial at the time of death.

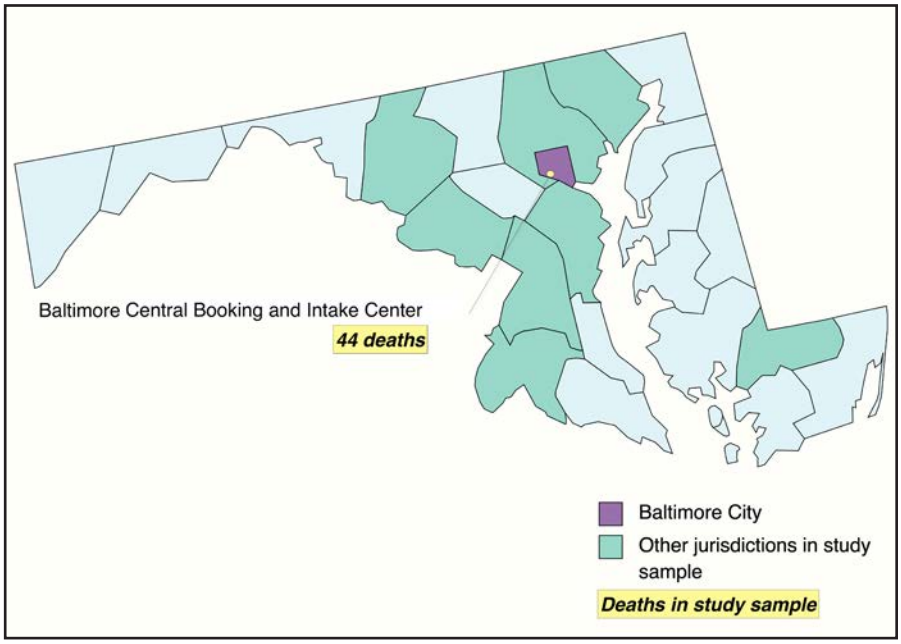


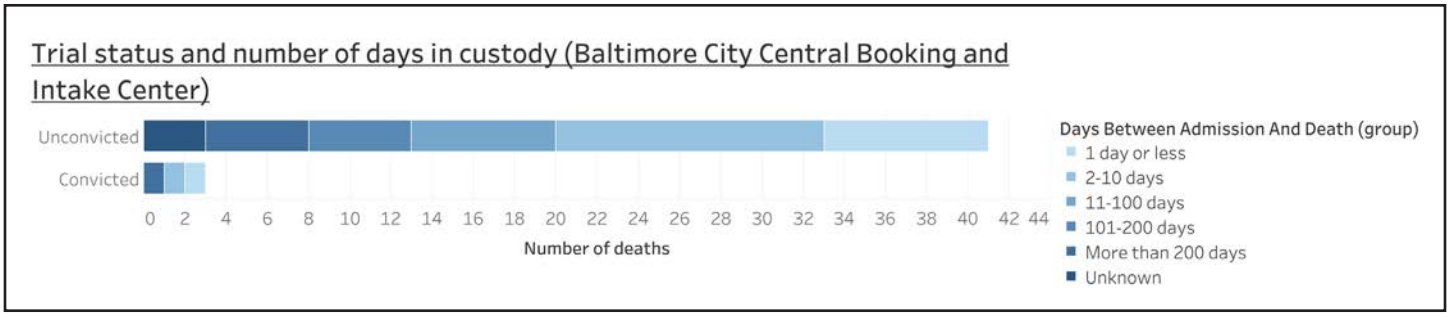


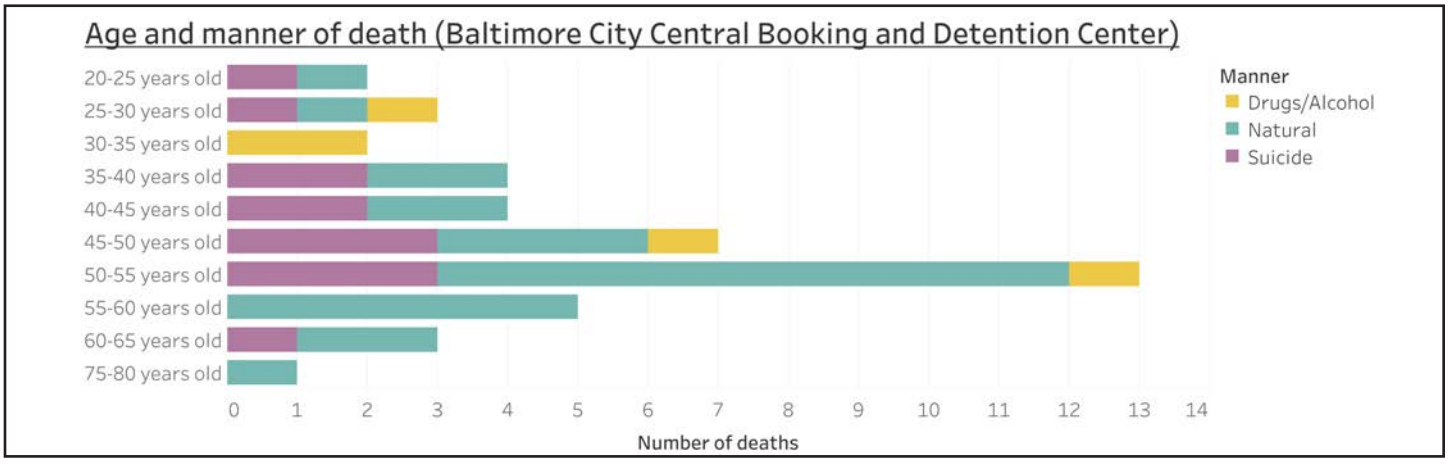


Baltimore Central Booking and Intake Center

Our sample contained a total of 44 deaths in Baltimore Central Booking and Intake Center. Of these decedents, 28 were identified as Black men, 13 as white men, 1 as a Hispanic man, 1 as an Asian man, and 1 as a Pacific Islander man. The most common manner of death was natural (n=26), followed by suicide (n=13), and drugs/alcohol (n=5). The overall most common cause of death was asphyxia-hanging (n=10), while the most common cause of natural death was hypertensive arteriosclerotic cardiovascular disease (n=3). The average age for all deaths was 46.73 years, while the average age for natural deaths was 50.31 years. The median length of stay in the detention center prior to death was 9 days (min: 0 days; max: 1093 days). 93.18 percent of decedents (n=41) were unconvicted/awaiting trial at the time of death.

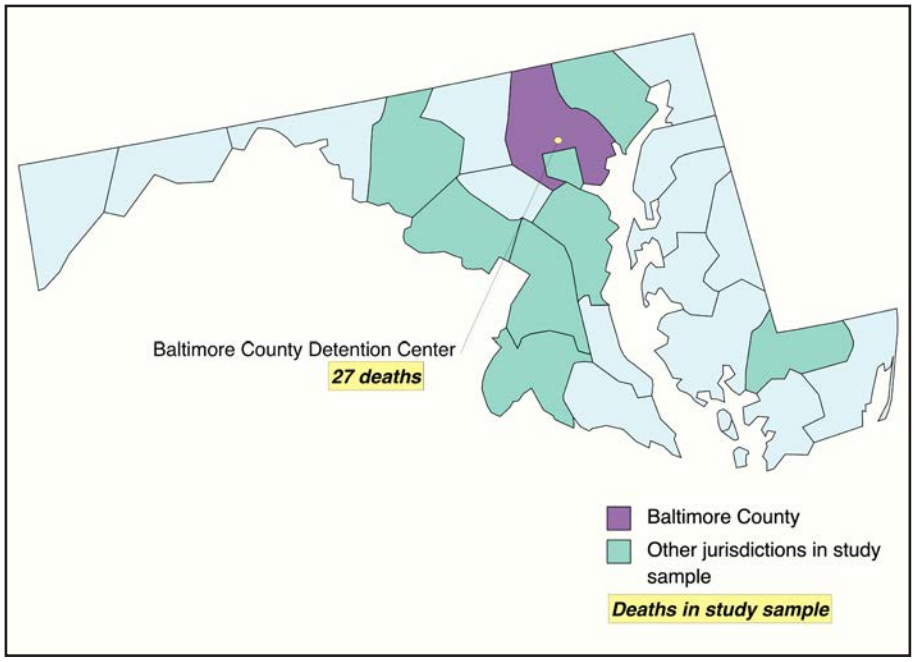


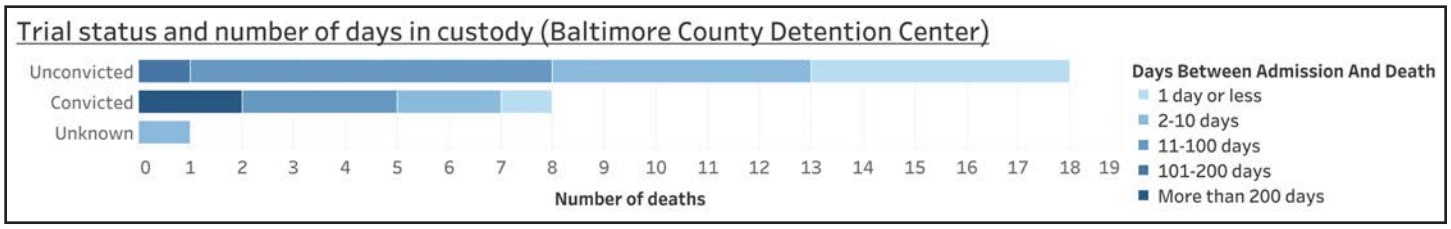


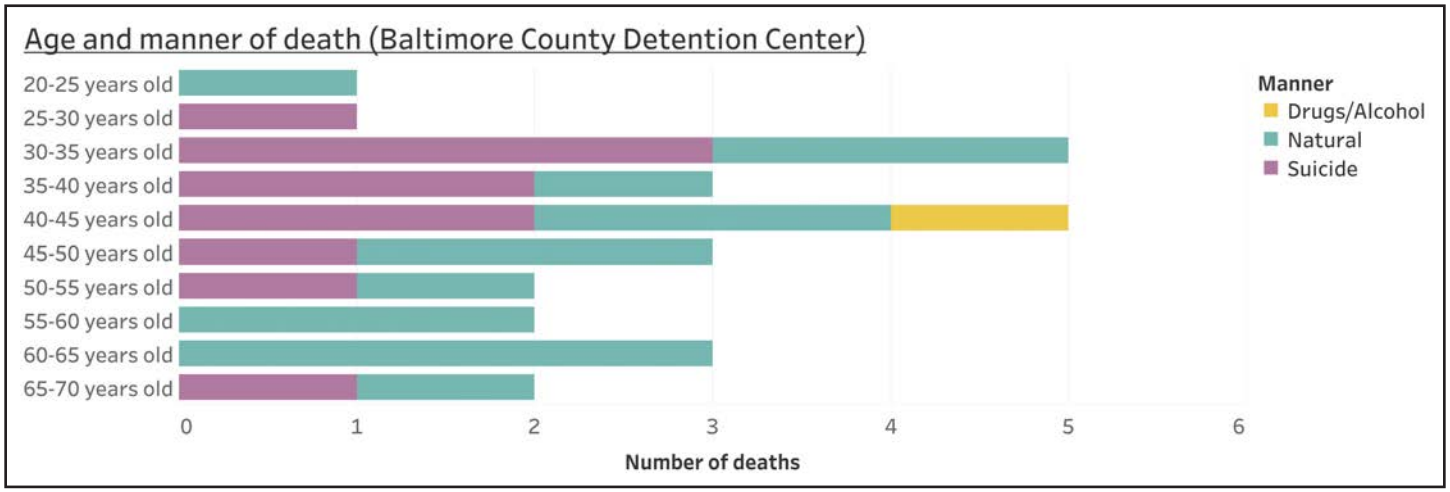


Baltimore County Detention Center

Our sample contained a total of 27 deaths in Baltimore County Detention Center. Of these decedents, 14 were identified as Black men, 10 as white men, 1 as a Black woman, and 2 as white women. The most common manner of death was natural (n=15), followed by suicide (n=11) and drugs/alcohol (n=1). The overall most common cause of death was hanging (n=7), while the most common cause of natural death was cardiac arrest (in one case called "cardiac issues") (n=4). The average age for all deaths was 44.63 years, while the average age for natural deaths was 48.13 years. The median length of stay in the detention center prior to death was 10 days (min: 0 days; max: 306 days). Trial status for one decedent was omitted. Of the decedents for whom such information was available, 69.23 percent (n=18/26) were unconvicted/awaiting trial at the time of death.

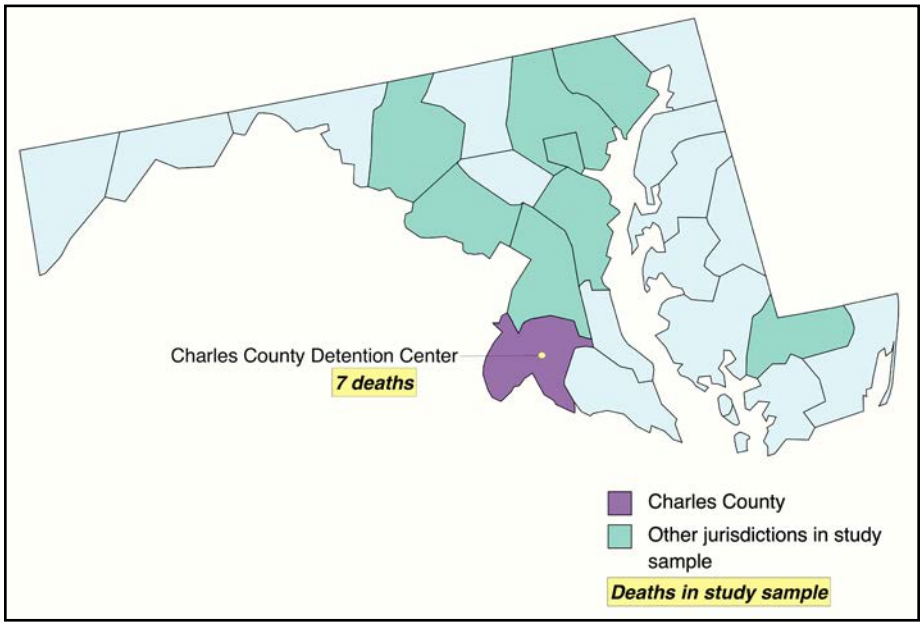


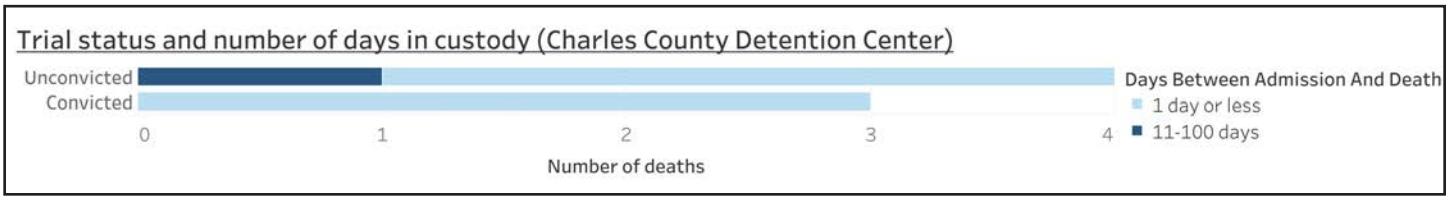


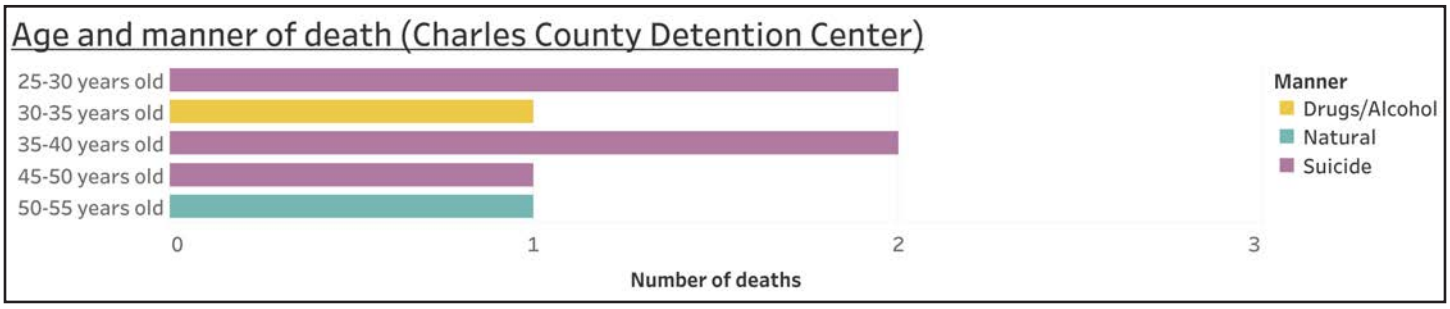


Charles County Detention Center

Our sample contained a total of 7 deaths in Charles County Detention Center. Of these decedents, 2 were identified as Black men, 3 as white men, and 2 as white women. The most common manner of death was suicide (n=5), followed by drugs/alcohol (n=1) and natural (n=1). The data reported by Charles County Detention Center did not include cause of death information adequate for inclusion in this analysis. The average age for all deaths was 36.71 years. We could only calculate age of death for one natural death; that age of death was 51 years. The median length of stay in the detention center prior to death was 3 days (min: 0 days; max: 35 days). 57.15 percent of decedents (n=4) were unconvicted/ awaiting trial at the time of death.

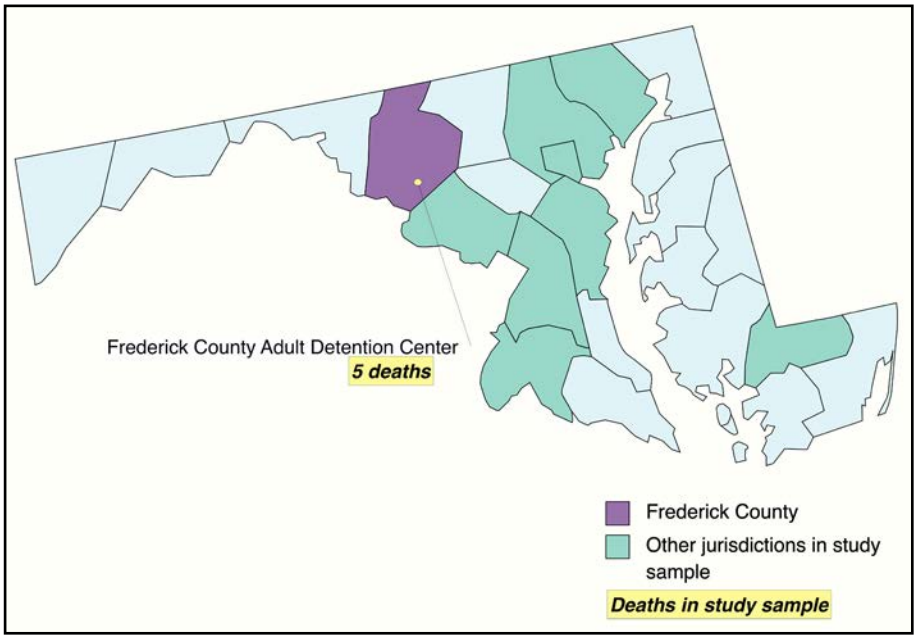


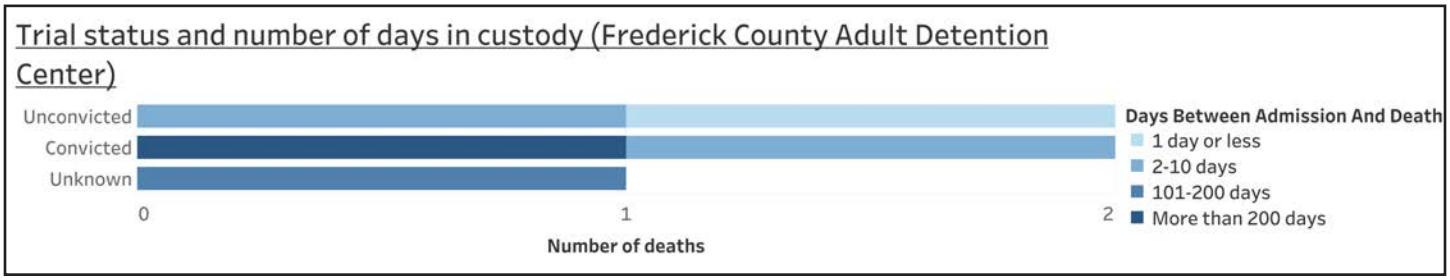


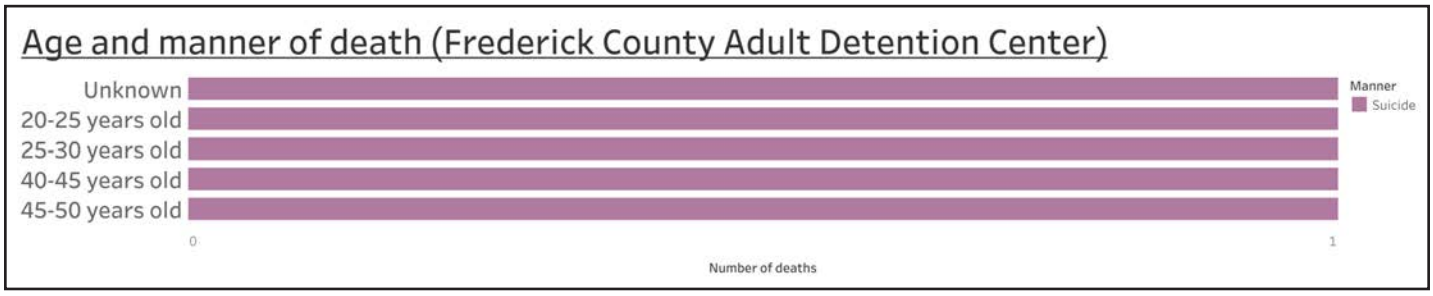


Frederick County Adult Detention Center

Our sample contained a total of 5 deaths in Frederick County Adult Detention Center. Of these decedents, 4 were identified as white men and 1 as a white woman. The data reported by the Frederick County Detention Center includes only suicide deaths, and does not include cause of death information adequate for inclusion in this analysis. Ages are provided only for four of the five decedents; the average age of death based on the data provided is 34 years (n=4). The median length of stay in the detention center prior to death was 2 days (minimum 0 days; max: 973 days). 60 percent of decedents (n=3) were unconvicted/awaiting trial at the time of death.

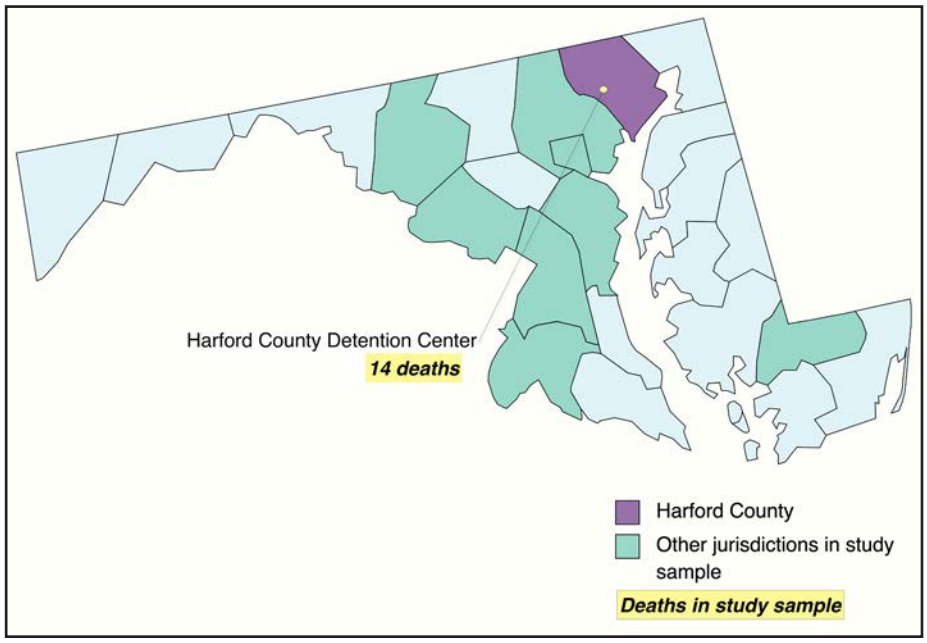


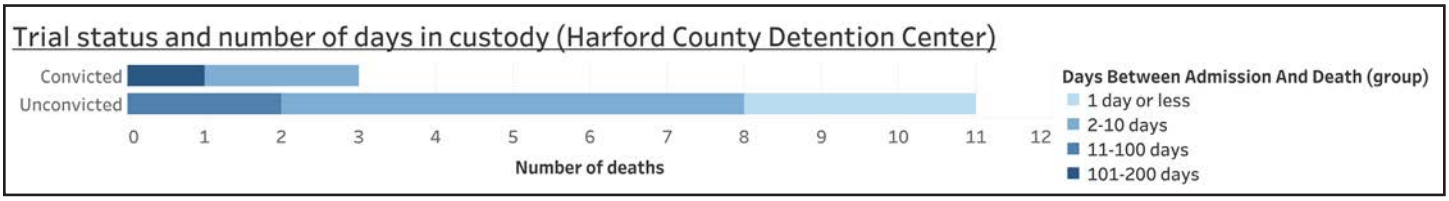


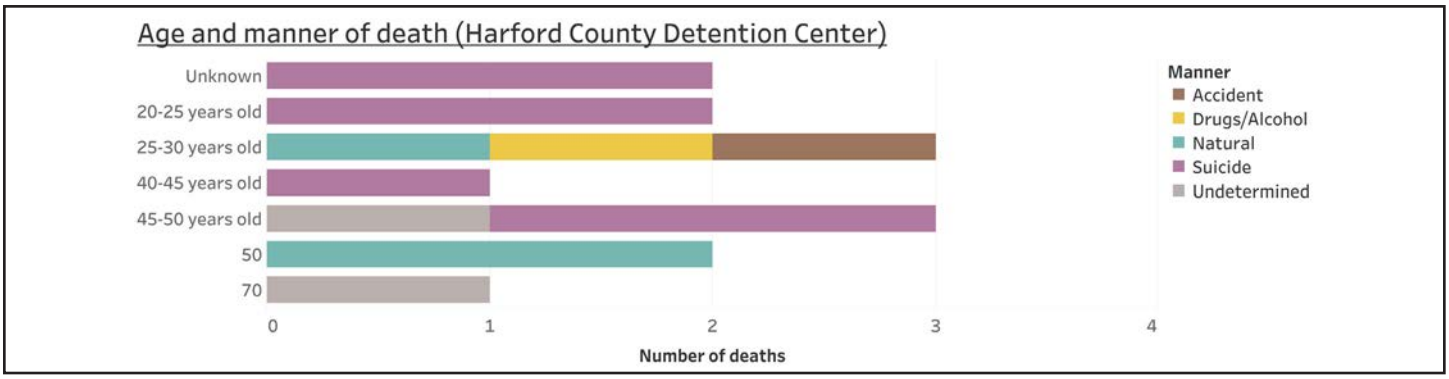


Harford County Detention Center

Our sample contained a total of 13 deaths in Harford County Detention Center. Of these decedents, all 13 were identified as white men. The most common manner of death was suicide (n=6), followed by natural (n=3), undetermined (n=2), drugs/alcohol (n=1), and accident (n=1). All three natural deaths are attributed in the reported data to cardiac arrest. The average age for all deaths was 40.5 years, while the average age for natural deaths was 45.3 years. The median length of stay in the detention center prior to death was 6 days. 84.62 percent of decedents (n=11) were unconvicted/awaiting trial at the time of death.

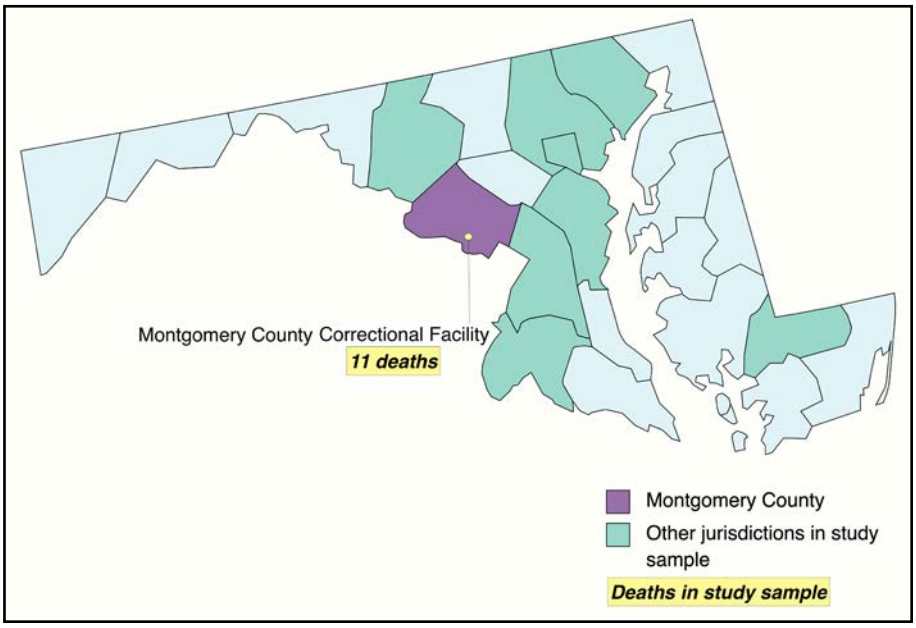


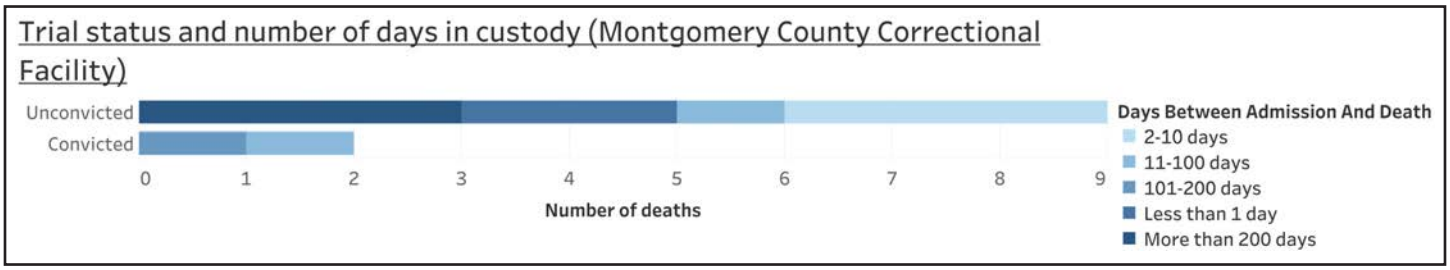


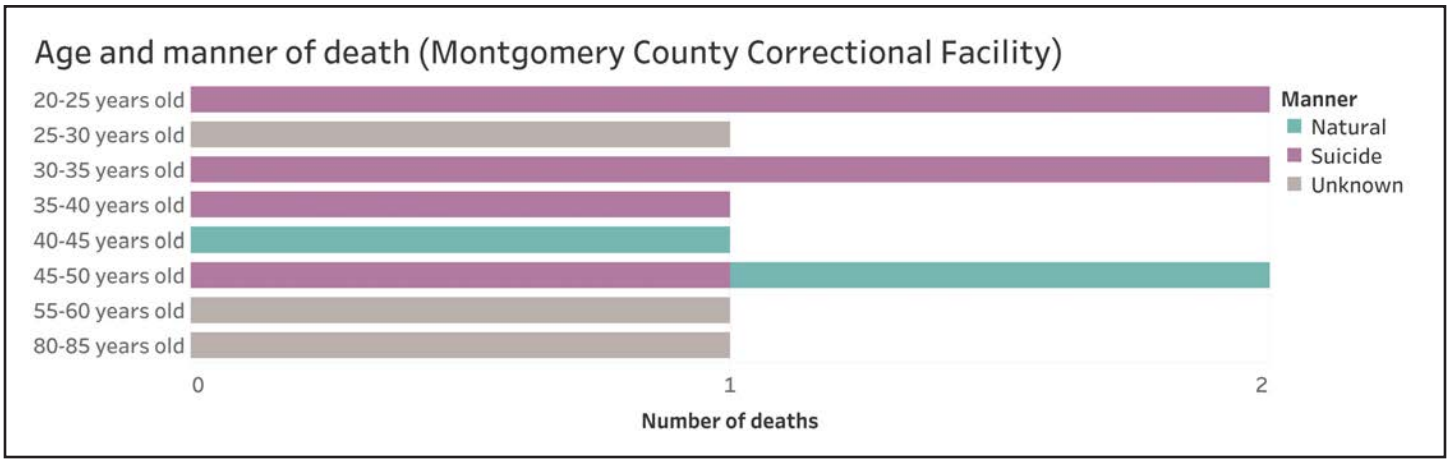


Montgomery County Correctional Facility (+MCDC)

Our sample contained a total of 11 deaths in Montgomery County Correctional Facility, including Montgomery County Detention Center (MCDC). Of these decedents, 6 were identified as Black men, 4 as white men, and 1 as a Black woman. The most common manner of death was suicide (n=6), followed by natural (n=2). Manner of death information for 3 deaths was unreported. The data reported did not include cause of death information adequate for inclusion in this analysis. The average age for all deaths was 40.9 years, while the average age for natural deaths was 46 years. The median length of stay in the detention center prior to death was 11 days (min 0 days; max: 797 days). 81.81 percent of decedents (n=9) were unconvicted/awaiting trial at the time of death.

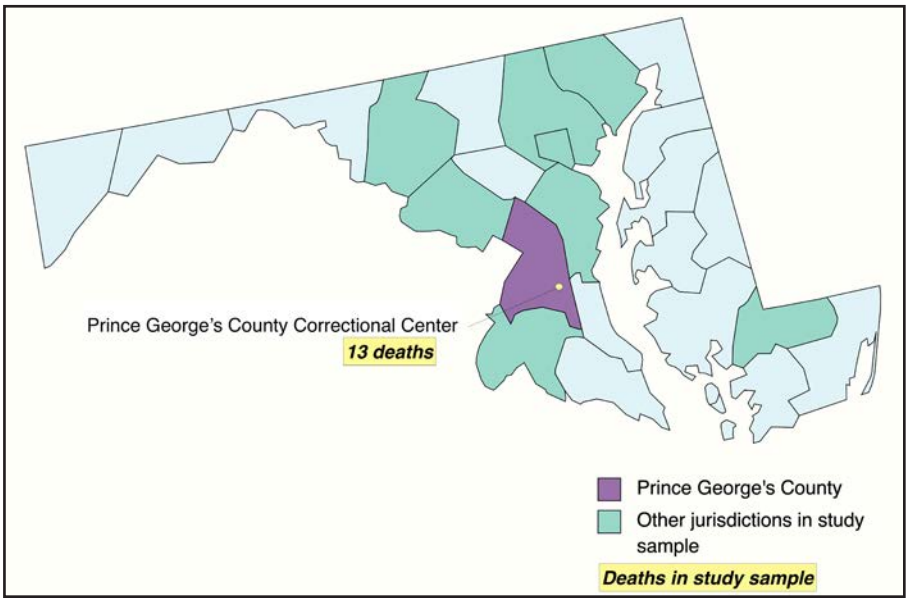


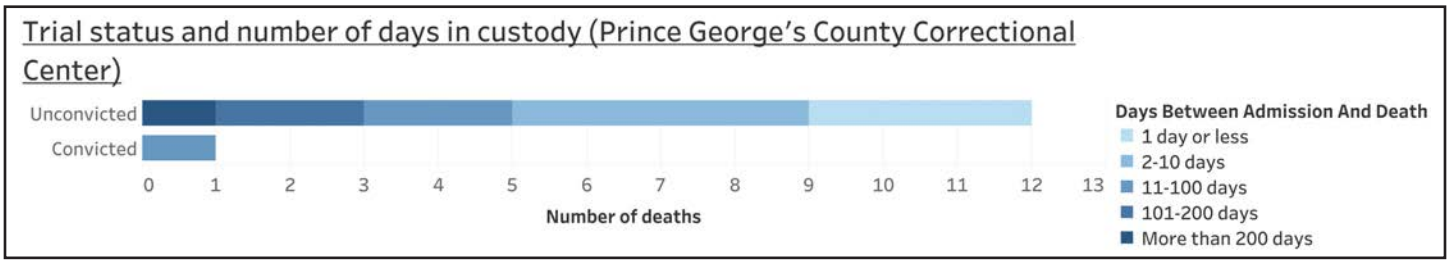


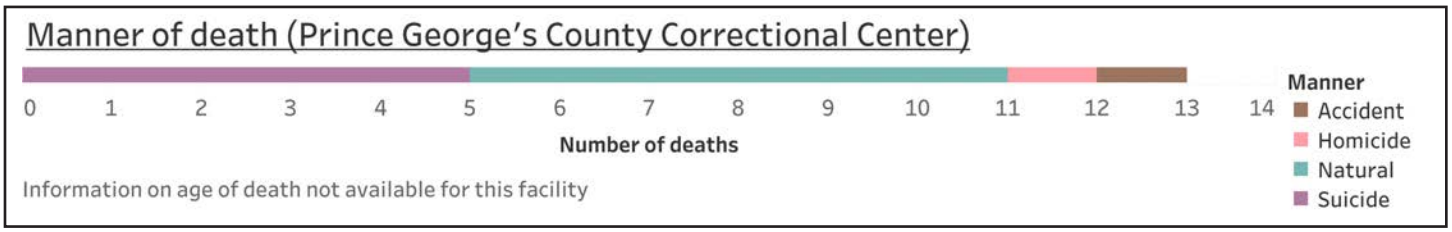


Prince George's County Correctional Center

Our sample contained a total of 13 deaths in Prince George's County Correctional Center. Of these decedents, 10 were identified as Black men, 2 as white men, and 1 as a Hispanic man. The most common manner of death was natural (n=6), followed by suicide (n=5), homicide (n=1), and accident (n=1). The data reported did not include cause of death information adequate to inclusion in this analysis. No ages could be calculated from the data reported. The median length of stay in the detention center prior to death was 8 days (min: 1 day; max: 910 days). 92.31 percent of decedents (n=12) were unconvicted/ awaiting trial at the time of death.

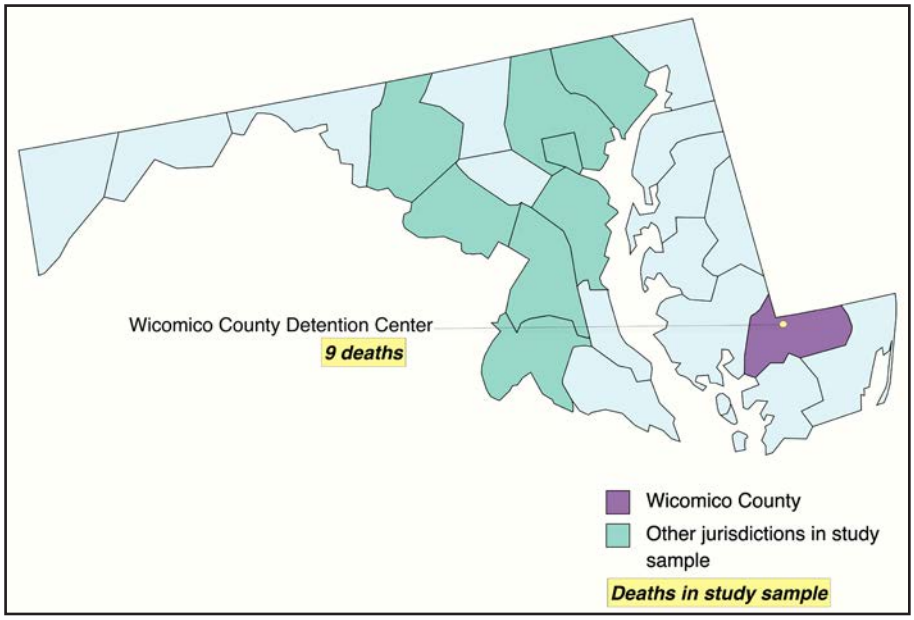


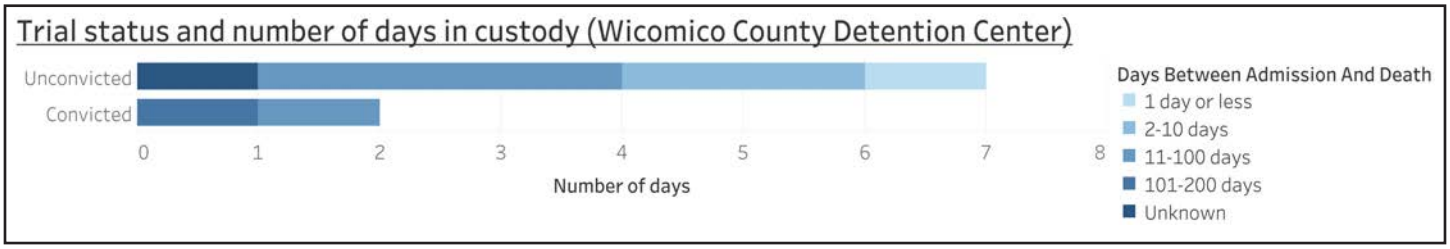


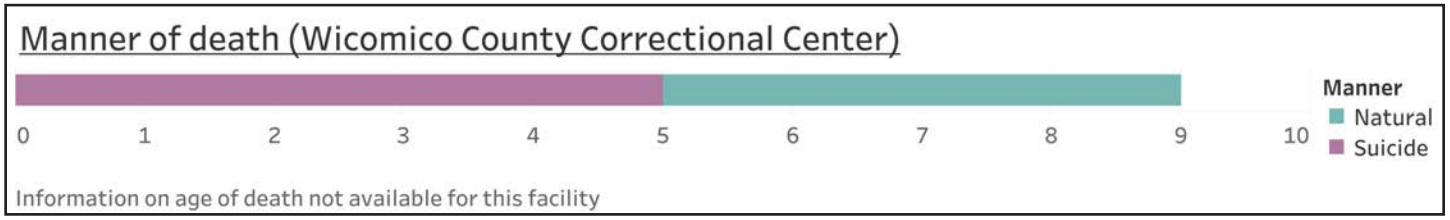


Wicomico County Detention Center

Our sample contained a total of 9 deaths in Wicomico County Detention Center. Of these decedents, 2 were identified as Black men, 6 as white men, and 1 as a white woman. The most common manner of death was suicide (n=5), followed by natural (n=4). The data reported included no cause of death information for suicide deaths. The most common cause of natural death was "cardiovascular disease" (n=2). No ages could be calculated from the data reported. Date of admission for one decedent is omitted from the data. The median length of stay in the detention center prior to death, calculated from the 8 provided values, was 18 days (min: 1 day; max: 138 days). 77.78 percent of decedents (n=7) were unconvicted/ awaiting trial at the time of death.







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