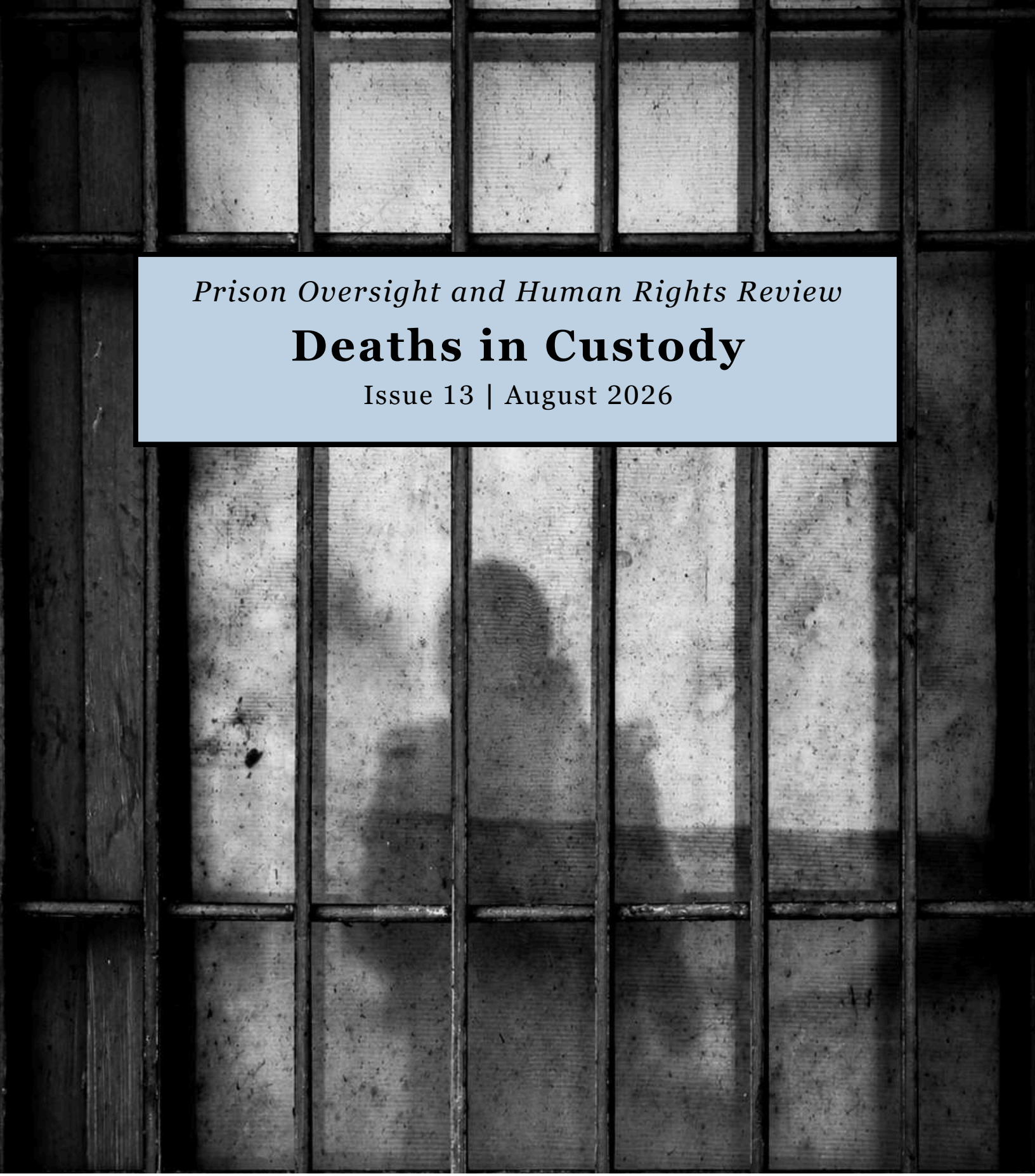

Prison Oversight and Human Rights Review

Deaths in Custody

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NETWORKS
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International Corrections & Prisons Association

The ICPA Network on External Prison Oversight and Human Rights is committed to bringing together various agencies responsible for external prison oversight to share information and exchange best practices and lessons learned.

For more information about the Network and its activities, please visit:
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The University of Texas at Austin
Prison and Jail Innovation Lab
Lyndon B. Johnson School of Public Affairs

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Table of Contents

Message from the Chair

Michele Deitch

Michele Deitch, J.D., M.Sc

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Michele Deitch, chair of the ICPA's Network on External Prison Oversight and Human Rights, is a Distinguished Senior Lecturer at the University of Texas at Austin, where she holds a joint appointment at the Lyndon B. Johnson School of Public Affairs and at the UT School of Law and directs the Prison and Jail Innovation Lab (PJIL), which is home to the National Resource Center for Correctional Oversight. Professor Deitch is widely recognized as one of the leading experts in the U.S. on the issue of correctional oversight and prison reform, and she has written and published extensively on these topics. She also advises policymakers and agencies around the U.S. on prison and jail conditions issues, on deaths in custody, and on the development of independent correctional oversight bodies. In 2019, the National Association for Civilian Oversight of Law Enforcement (NACOLE) awarded her the Flame Award for her contributions to the field of prison oversight.

Professor Deitch served as the original drafter of the American Bar Association's Standards on the Treatment of Prisoners. Prior to entering academia, she served as a court-appointed monitor of prison conditions in Texas and as a criminal justice policy advisor to the Texas Legislature. She holds a J.D. from Harvard Law School, an M.Sc. from Oxford University, and a B.A. from Amherst College.

Deaths in custody represent the ultimate failure of a correctional system, which is charged with keeping its residents safe, healthy, and alive. Every person who enters a prison or jail is placed under the government's control and is fully dependent upon that correctional agency to meet their needs and ensure their well-being. When someone dies behind bars, it is our obligation to ask not only how that person died, but whether the death could have been prevented, and what changes are needed to prevent other deaths in the future. Independent oversight is essential to bring greater transparency and accountability to these deaths.

This latest volume of the newly renamed *"Prison Oversight and Human Rights Review"* provides insights into some of the ways that oversight professionals and advocates for human rights review, investigate,

and analyze deaths in custody. As the authors of these articles make clear, the official determination of the cause of a particular death (whether it has been classified as "natural," "accidental," "suicide," "homicide," or "undetermined") should be the beginning of any inquiry, not the conclusion. For example, a death labeled "natural" may reflect delayed medical treatment, a missed diagnosis, inadequate staffing, or a failure to respond to a medical emergency. Suicides may indicate a failure of a correctional agency to provide mental health care, poor observation practices, or inadequate screening on admission. Overdoses could point towards a problem with drugs entering a facility as well as a lack of treatment programs. Homicides may reveal problems with staffing levels, supervision, classification, and institutional culture. Context is everything when it comes to understanding a particular death.

What's more, analyzing patterns in deaths over time can reveal systemic problems, and can highlight facilities or issues that need closer attention and significant improvement. In other words, deaths in custody provide us with windows into conditions inside prisons, and thus they must be a priority area of focus for independent oversight bodies.

Several articles in this volume remind us that death reviews must be about more than assigning blame. Indeed, none of the articles focus on staff wrongdoing, but rather on system improvement. Preventing future deaths requires looking beyond the immediate error to the policies, practices, training, staffing, and institutional culture that allowed the mistakes to occur. A strong death review asks not simply, "who made a mistake?" but "what made this mistake possible, and could the same conditions lead to another death?" In this way, effective oversight can lead to meaningful systemic changes.

This set of articles offers examples from the United States, New Zealand, and England and Wales demonstrating how independent oversight can help turn individual tragedies into opportunities for prevention:

- We see how reports published by New York's oversight body documenting dangerous conditions of confinement played a critical role in mobilizing state policymakers to take action when confronted with two highly publicized deaths of individuals at the hands of correctional officers.
- From New Jersey, we learn that even a relatively simple analysis of mortality data by an oversight body can help identify troubling concentrations of unnatural deaths, generate more targeted questions about individual death cases, and lead a corrections agency to publish more information.
- New Zealand's experience demonstrates the need for an oversight body to be capable of combining death investigations with inspections, review of complaints, and thematic analysis.
- England and Wales have a layered system of deaths investigation, with critical and different roles played by various oversight entities. This approach shows the benefits of having multiple forms of scrutiny but also points to the need to ensure that recommendations from all these different entities get implemented and sustained.

Most importantly, these articles remind us never to lose sight of the people at the center of death investigations. Each person who dies in custody is a person with a unique story, a family, and hopes and dreams that have been curtailed. The bereaved families left behind are often overlooked, yet they deserve prompt notification, truthful answers, meaningful participation in an investigation, and support.

One article offers a provocative vision of how biometric monitoring could potentially provide families with an early warning system about the risks faced by their loved ones, while properly cautioning that such innovations must never become another form of intrusive surveillance or a way for agencies to shift their duty of care onto families.

Our hope in publishing this volume is that oversight bodies around the globe will be encouraged to treat every death in custody as both an individual human tragedy and a call to examine systemic issues that may have contributed to the death. Oversight bodies are especially well-equipped to collect reliable and objective information, ask difficult questions, make findings public, offer recommendations, and assess changes made in response to those recommendations. Those are among the most important steps we can take to honor those who have died in custody and to protect those who remain incarcerated.

In addition to the thematic articles, each issue of the Network's Review features one jurisdiction's oversight body to provide a closer look at its work, its mandate, and its impact. In this way, we hope to showcase the diversity of oversight bodies that exist around the world and to provide models for those jurisdictions that may be considering developing or strengthening their own correctional oversight structures. In this issue, we feature the Office of the Correctional Ombudsperson in New Jersey, USA, led by Ombudsperson Terry Schuster. A relatively new oversight body, completely revamped in 2022, the office has quickly gained a reputation for excellence in its work, for its thoughtful and collaborative approach to handling routine inspections, individual complaints, and thematic reviews, and for gaining the trust of the public and policymakers alike. And, in just a few short years, it has already had a measurable impact through its oversight activities. Independent oversight may not yet be a standard feature of every state in the USA, but New Jersey's experience can certainly provide an excellent template as oversight becomes a more familiar concept nationally.

Finally, I wish to thank the members of the ICPA Network leadership team and the Prison and Jail Innovation Lab (PJIL) team for their hard work in producing this volume. In particular, Kate Eves, who serves as a Special Advisor to our Network, was the primary editor of this issue (as well as a contributor). And Allison Paranka, Senior Administrative Program Coordinator at PJIL, provided administrative support, editorial assistance, and graphic design. Network Vice-Chair and PJIL's Associate Director, Alycia Welch, and I worked closely with Kate and Allison on both the content and the design.

We welcome your feedback on this biannual publication, with each volume on a different thematic topic. Our hope is that our Network Review will be an invaluable resource for advancing humane, transparent, and accountable correctional systems by bringing together perspectives and lessons from across jurisdictions.

Michele Deitch
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Director, Prison and Jail Innovation Lab (PJIL)

August 2026

Deaths in Context: Connecting Conditions to Manners of Death

Lillian McLemore & Andrea Armstrong

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Andrea Armstrong is a nationally recognized legal scholar, law professor, and MacArthur Fellow whose work reimagines public accountability and human dignity within systems of incarceration. Through interdisciplinary research and public engagement, she brings hidden carceral realities into public view and advances new ways of understanding justice, memory, and civic responsibility.

Introduction

Prisons and jails are complex, generally opaque systems.[1] Deaths in custody are often inconsistently and inaccurately self-reported by prisons, jails, and detention centers. Journalists and researchers often struggle to acquire reliable information, including the circumstances of death.[2] At the same time, we know that prison and jail conditions can be deadly: from forced labor in unprotected work environments, to limited access to preventative and diagnostic healthcare, to insufficient treatments for mental health disorders, and to security failures leading to extreme violence, heavy contraband traffic, and undeterred drug use,[3] many deaths occurring within the prisons, jails, and detention centers expose a facet of our system's failures.

Reducing preventable deaths requires more than documenting that a death occurred. Instead, facility officials, researchers, oversight bodies, and advocates must examine the cause and manner of death within the context of the prison, jail, or detention center's operations and policies. By studying these deaths in context, we can piece together how and why our prisons, jails, and detention centers are failing the people in their custody.

Manners of Death

When confronted with a death in custody, the first question is often "how did the person die?" In some cases, it may seem obvious, such as a death from an extended and documented battle with cancer or when a person hangs themselves in their cell. However, it is the responsibility of the coroner or medical examiner to determine the *official* cause and manner of death. "Cause of death is the medical condition or injury that led to an individual's death. Causes may include diseases (e.g. cancer, heart disease), injuries (e.g. trauma from a fall), intoxication (e.g. drug overdoses), or other situations (e.g., asphyxiation)."[4] "Manner of death is a classification that describes how an individual died," i.e. the circumstances of their death. In the U.S., there are generally five manners of death, though some jurisdictions employ different criteria in classifying manner of death.[5] The five categories are: undetermined (cause cannot be established), natural (internal, such as "disease or aging"), suicide ("intentional self-harm"), accidental ("unintentional injury or accident," including drug use, car accidents), and homicides ("intentional acts by others").[6]

To fully understand deaths in custody requires more than determining just the cause and manner of death.

To fully understand deaths in custody, however, requires more than determining just the cause and manner of death. Prisons, jails, and detention centers control nearly every facet of an incarcerated person's life—from a person's safety and access to healthcare to their diet and everything in between. Even deaths that appear simple, such as a natural manner of death caused by a documented disease, may still be preventable depending on the diagnosis and healthcare provided by the facility and the availability of prompt and aggressive treatment. This essay explores the five manners of death, and for each manner of death,

poses questions for officials, researchers, oversight bodies, and advocates seeking to identify potential connections between the death and conditions behind bars.

A. Undetermined

In September 2022, 35-year-old LaShawn Thompson was found unresponsive in his cell in Atlanta's Fulton County Jail, covered in "feces and body lice." [7] He was pronounced dead within the hour. The county medical examiner reported his cause of death as undetermined. After a public outcry, a second death review was commissioned from an independent party. The second report determined LaShawn's cause of death as complications due to "severe neglect with untreated decompensated schizophrenia as a contributing cause," as well as dehydration, malnutrition, and severe body insect infestation. His death was reclassified as a homicide, and the U.S. Department of Justice opened an investigation, ultimately finding that the jail's operations violated the Constitution.

A death is classified as undetermined if there is less than 50% certainty of how the death occurred.[8] An analysis of deaths in custody across the United States between October 1, 2019, and September 30, 2023, indicated that a stunning 40% of deaths were listed as undetermined.[9] LaShawn's example shows that a thorough and complete investigation into an in-custody death can reveal facts that advance our understanding of the circumstances and causes and indicate ways to prevent future deaths.[10]

Potential investigative questions for officials, researchers, oversight bodies, and advocates:

- Were any interviews conducted with incarcerated individuals or family members close to the decedent following their death?
- Who determines if an autopsy is necessary when a death occurs at this facility?
- Was an autopsy performed, and did the examiner have access to the decedent's full medical file?
- Was any other investigation performed, and if yes, did it include full access to the decedent's security, grievance, and medical file?

B. Natural

Jason "Poppy" Phillips was incarcerated in New York's Greene Correctional Facility in December 2023 when he began struggling to breathe.[11] For hours, Poppy and his cellmate begged for help as his breathing worsened. Nurses checked on him twice but concluded he was "playing games." He died while his cellmate screamed for help. Poppy's epiglottis, a piece of cartilage in the throat, was infected, and the swelling slowly choked him to death. Epiglottis infections are rare but easily treated, and 99% of patients recover.

In Central Mississippi Correctional Facility, a prison across the country, Susie Balfour was diagnosed with breast cancer in December 2021, two weeks before her release from prison. [12] She ultimately died from the disease in August 2025.

These two deaths, while different, are both considered natural. "Natural" deaths, or deaths due to medical illness, are the leading cause of death in prison.[13] Yet many of these deaths could have been prevented or delayed with access to proper healthcare.[14] Poppy died because prison and medical staff refused to provide emergency healthcare. Susie's cancer would likely have been caught earlier had the prison healthcare included standard preventative and diagnostic testing.

Medical care behind bars is frequently inadequate and delayed,[15] and in some cases, provided by unlicensed staff.[16] The fact that someone is incarcerated might influence their treatment, from being ignored to being denied information about their condition to being denied treatment for symptom management.[17] Transportation and security for medical appointments are coordinated by prison staff, which can cause serious logistical issues.[18] One prison medical director reported that they often do not have adequate staffing to take incarcerated patients to their appointments.[19] Additionally, there are often fees associated with seeing medical staff in prison, which deters patients.[20] All of these delays in healthcare can result in permanent damage and death.[21]

Potential investigative questions for officials, researchers, oversight bodies, and advocates:

- How many medical professionals are full-time/part-time on-site at the facility, and what are their licensing credentials and training?
- Does the facility screen individuals entering custody and periodically afterward for common health issues such as colorectal or breast cancer?
- How do incarcerated individuals request and access care at this facility?
- How long are wait times to see a medical professional at the facility?
- Which fees are associated with requesting healthcare at the facility?

C. Suicide

In October 2017, 26-year-old Robert DeAngelo Carter hanged himself while in solitary confinement at Alabama's Holman Correctional Facility.[22] His friend, who was incarcerated with him, remembers him as soft-spoken and honest. The day he hanged himself, Robert screamed repeatedly from his cell that he was going to kill himself. Two hours later, he was dead. He was the third person to complete suicide at Holman that year.

Over half of people who are incarcerated in a state prison have mental health conditions, but only one in four prisoners have received any professional help while incarcerated.[23] Since 2017, rates of death by suicide in custody in the U.S. have spiked.[24] Half of all suicides occurring in prisons and jails, like Robert's suicide, happen in solitary confinement.[25] Despite its deadly potential, the use of solitary confinement is largely unregulated and often left to the discretion of security staff.[26]

Over half of people who are incarcerated in a state prison have mental health conditions, but only one in four prisoners have received any professional help while incarcerated.

Potential investigative questions for officials, researchers, oversight bodies, and advocates:

- Which mental health programs are offered at your facility, and how many people receive periodic treatment?
- What measures are in place to identify people with suicidal ideation, and what is the protocol when these individuals are identified?
- What training do staff receive to recognize suicide risks among the population they supervise?
- How many isolation or segregation cells do you have at your facility? How many people do those cells house, and for how long? How often are they at max capacity?
- What measures are available to reduce reliance on solitary confinement, such as diversion practices, classification reassessment, or program referrals?
- How many mental health professionals are full-time/part-time on-site at the prison, and what are their licensing credentials?
- What post-incident protocol is used following a suicide attempt? A completed suicide?

D. Accidental

In October 2024, Jayson Murphy's cellmate at Lebanon Correctional Institution in Ohio watched him light up a piece of paper soaked in K2, a potent synthetic drug, and inhale. [27] That night, they laughed together before falling asleep, but Jayson never woke up. The coroner ruled the death an overdose, but prison authorities never attempted to determine how the drugs entered the facility. Thirteen people incarcerated in Ohio died from K2 overdoses in 2024.

Deaths designated as "accidental" refer to deaths due to an "unintentional injury or accident," i.e. an external source to the body including overdoses, car accidents, drownings, etc.).[28] Drug overdose deaths in custody have increased in recent years,[29] and drug overdose is the leading cause of death for people recently released from prison.[30] Drugs may enter prison through a variety of means, including drug-soaked paper in the mail, smuggling, and drones.[31] Yet security measures like switching to electronic mail and investing in anti-drone technology have done little to staunch the inflow of drugs.[32] Notably, a significant amount of drugs enter facilities via correctional staff.[33]

Potential investigative questions for officials, researchers, oversight bodies, and advocates:

- Does this facility have any substance use disorder programming, including suboxone and methadone programming?
- Does the facility have medical and security protocols/trainings for identifying and treating individuals suffering from withdrawal or overdose?
- Is naloxone available throughout the facility or only through medical staff/units?
- What security precautions does this facility use to combat contraband trafficking, including searches of staff?
- Do incarcerated people receive the necessary training and protective gear to perform assigned work in safe and regulated environments?

E. Homicide

In January 2026, Jimmy Trammell, Ahmod Hatcher, Teddy Jackson and Silas Westbrook were killed during their incarceration at Washington State Prison in Georgia in a fight involving makeshift weapons. [34] Another dozen men were injured, and twelve men were charged with murder. Staffing levels at the prison were just 28% of authorized staffing.

Prison homicides may indicate catastrophic security failings, staffing shortages, and unaddressed trauma among the incarcerated.[35] Contraband such as prison-made weapons, drugs, and cell phones fuel violence and homicides in prisons.[36] Like contraband drugs, contraband cellphones enter facilities because of security failures and correctional staff engaged in trafficking.[37] Moreover, when prisons are overcrowded, violence increases.[38]

Potential investigative questions for officials, researchers, oversight bodies, and advocates:

- What is this prison's maximum population capacity? What is this prison's current population?
- What is the security classification and risk assessment process, including periodic review and adjustment?
- Are people in the facility being housed consistent with their classification levels?
- What sort of security policies does this facility employ to mitigate contraband, including the risk of potential introduction of contraband by staff?
- What are the supervision protocols for where the homicide occurred and was there prior violence either in the same area or by the same people, including staff?

Strategies for Reducing Preventable Deaths

There is no national standard death investigation process in the United States, which is an impediment to transparency, accountability, and improvement.[39] A standardized code regulating custodial death investigations could create better, more transparent and regular death investigation outcomes, identify trends in custodial deaths, and support officials, researchers, oversight bodies, and advocates in mitigating future deaths.[40]

There is no national standard death investigation process in the United States, which is an impediment to transparency, accountability, and improvement.

Mandating that all deaths in custody be referred to an independent forensic pathologist ensures that a neutral party is involved in the death investigation.[41] The results of these findings should be analyzed within the specific context of the facility's operations and policies in conjunction with confidential interviews with people incarcerated alongside the decedent. Both the gathering of evidence, including interviews, and analysis of that evidence should be conducted by an independent authority to ensure the findings are perceived as objective, thorough and neutral.[42]

Beyond individual death reports, each facility should submit a report on custodial deaths for public review at least annually (or quarterly, depending on the size of the facility). These reports can identify patterns, and help advocates flag certain facilities as being especially deadly, investigate why, and better advocate for change.

Conclusion

When we collect, publish, and share accurate information about deaths in custody, we push policy officials and administrators of prisons, jails, and detention centers to take accountability, implement critical change, and pursue justice for those who have died behind bars and their families. Offering the public, legislators, and prison officials undeniable facts and data about individual deaths occurring behind bars, as well as evidence of patterns of deaths, bolsters arguments for change. These analyses can and should guide any changes implemented by policymakers seeking to prevent deaths and reduce prison mortality.

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Conducting Reviews of Health-Related Deaths in Custody with the Goal of System Improvement

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In many countries, one or more death reviews may be conducted after a death in custody. The main goal of such death reviews generally falls into one of two categories: accountability or system improvement. An accountability review – the most common type – aims to determine if the death was the result of a crime or serious employee misconduct. Less common, but arguably more important from the standpoint of prevention, a system improvement review aims to determine if there are system errors which contributed to the death (or, even if they did not contribute to the current death, might cause one in the future). While a review might *focus* on one of these two aims, there is overlap: accountability reviews can also point out areas for system improvement, and a system improvement review can reveal criminal or employee misconduct.

Oversight bodies (OB) need to understand the important elements of death reviews, either as producers of the reviews (to know how to conduct them) or as consumers (to assess their completeness and validity). This article will help OB in those roles by describing the important elements of death reviews

that focus on system improvement where the death is health-related. The article is informed by my experience with such reviews as a clinician in the U.S. However, the principles I describe are applicable to a prison[1] death in any country. And, while the article applies to the review of health-related deaths, as explained later, this does not mean that reviews should exclude security staff. Nor does it mean that the lessons learned from the review may not be relevant to security staff.

1. Timing

Determination of the best time to conduct the death review for system improvement ("DR-SI") must balance two competing needs. We want to complete it as soon as possible because if there are weaknesses in operational systems that put incarcerated individuals at risk, we want to fix those systems before they lead to another death. There is, however, an important reason *not* to conduct the DR-SI too soon. As discussed in more detail later, the DR-SI often benefits from the honest and open participation of employees who were involved in the death. But because those employees may be accountable for misconduct, or just fear that they might be, they are unlikely to openly share information with such accountability hanging over their heads. Thus, it is usually best to wait until all other accountability-focused reviews are completed, reassuring employees that any information they share will not result in harm to themselves.

In summary, to find the best time to conduct the DR-SI, first determine if the input of employees directly involved in the death will be of value. If it will, wait to conduct the DR-SI to the soonest time possible after any accountability-focused death reviews are completed. If it will not, conduct the DR-SI as soon as possible after all needed information has been collected.

2. Sources of information for the DR-SI

Medical Records

The importance of reviewing the medical record (MR) cannot be overstated. It is arguably *the* most important information source for a DR-SI. While a nurse can review part of the MR, whether or not a nurse is involved, the review must include a medical practitioner, preferably a physician. If the patient's mental health played any role in the death, the review must also include a mental health practitioner.

Because a paper MR is a simple linear document, its review is straightforward. Electronic MRs, however, are not simple linear documents and thus raise the question: What is the best way to review them? There are two options: in print or in the software in which they were created. I strongly recommend the latter. The reason is that the digital version of a MR contains context and data that may not have been – and sometimes cannot be – appreciated by reviewing a printed version. For example, the information contained within a hyperlink in the electronic record may not be produced in the paper version.

[1] I use the term prison in this article to broadly include facilities that incarcerate sentenced individuals, as well facilities that house those awaiting trial (sometimes referred to as remand or jail).

This discussion assumes there is a single MR, generated by health care professionals. This is not always the case. Thus, the OB must be aware of (and request and review) two groups of documents that may also contain medical information. **First**, in some prison systems, community-based professionals provide specialized care (e.g., mental health) within the prison and may record within their own MR system. **Second**, in small or rural prisons without full-time – or any – medical staff, medical screening and some basic care, such as first aid and medication administration, may be provided by security staff (who record this information within security, not medical, records).

In addition, security staff may collect information which, while its purpose is not for health care, may have medical content. For example:

1. **Admission full-body x-ray scans.** In many countries, individuals undergo these scans to detect drugs and other contraband. But they may contain other information, for example, they might show a fracture, which would help the OB determine if a fracture found at death occurred in prison, or prior to, incarceration.
2. **Drug testing.** Security staff may obtain drug samples for forensic reasons.
3. **Police hand-offs.** The officer bringing an individual to prison is expected to provide relevant information about the arrest, including details that may affect the person's health, e.g., if the officer saw the individual swallow something or heard them express suicidal ideation, or if the officer used force.
4. **Activity or incident logs.** Staff supervising living units usually log activity of incarcerated individuals, e.g., behavioral changes, the extent to which meals were or were not eaten, and visits from health care staff (that the health care staff may have failed to document in the individual's MR). In addition, various "incidents," such as uses of force, fights, mechanical failures (e.g., air conditioning breakdown), and medical emergencies, may trigger specific reports by staff with first-hand knowledge of the event.
5. **Biometric Scanning.** Prisons in some countries utilize biometric devices to monitor the health of incarcerated persons. There are two categories of devices: mounted and worn. Mounted devices are affixed to the ceiling or wall and use radar to monitor respiratory rate, heart rate, and general activity level. Most worn devices are bracelets, monitoring some combination of heart rate, oxygen level, temperature, and activity. These systems store historical data.

Voice, Video, and Email Communications

In many prisons, voice, video, and email communications between incarcerated individuals and family/friends are recorded. For voice and video communications, a transcript of the conversation may also be available. Such conversations can provide insight into the individual's state of mind, including suicidal ideation/intent, evidence of other psychiatric conditions, illness symptoms, and possible drug/contraband use.

Facility Videos

There are three types of video: closed circuit, hand-held, and body-worn. Closed circuit cameras are wall or ceiling mounted. Hand-held cameras are usually deployed in advance of a planned use-of-force event.

Finally, some security staff have body-worn cameras. Video can provide invaluable information for a DR-SI, for example: the appropriateness of an emergency response; whether the individual obtained illicit drugs; abnormalities in the individual's behavior or physical movement prior to death.

3. Participants in a DR-SI

In general, the review team should include individuals who know health care, individuals who know the current health care delivery system, and individuals who know the security system. Whereas the accountability-focused death review typically requires participants who have enough "distance" from the place and people involved in the death to assure that there are no conflicts of interest, the opposite is true for DR-SIs. They benefit from having at least some participants who are "closer" and therefore more familiar with the setting.

As an example, in a recent death I reviewed, a security officer had failed to conduct two required hourly checks. The individual was found dead on the third check, and had clearly been dead for some time. The officer was a *subject* of the accountability-focused death review. However, conducting the DR-SI requires a change in paradigm. For the DR-SI, the officer was an *expert* on the team. Indeed, who, other than the officer (and potentially colleagues who do the same job) know more about why the checks were not conducted, what system problems may have contributed to the behavior, and how best to fix the system so the error is not repeated?[2]

There is no "perfect" DR-SI review team. The composition of the team should be tailored to the nature of the death. Also, the team composition may change over the course of the review. For example, during the course of reviewing a death from a drug overdose that appeared to be accidental, the OB may gather information suggesting that it was intentional, at which point it would be valuable to add a mental health professional to the team, and to interview peers in the individual's housing unit to assess the individual's state of mind in the hours/days before their death.

4. Interpreting the official "manner of death"

In most countries, an external forensic authority (e.g., coroner) establishes the manner of death. The International Association of Coroners and Medical Examiners recognizes five categories of manners of death: natural, accident, suicide, homicide and undetermined; these or similar categories are used globally. Some OBs base their decision whether to investigate a death on that manner of death. They should not. Perhaps the most common error is when the OB declines to review a death because it was categorized as "natural." The word "natural" makes us view

The International Association of Coroners and Medical Examiners recognizes five categories of manners of death: natural, accident, suicide, homicide and undetermined; these or similar categories are used globally.

[2] This is the basis for my suggestion in Section 1 that DR-SIs be conducted after the accountability-focused death review has been completed: so that all participants can be candid, without fear of disciplinary action.

the death as inevitable rather than preventable, causing us to believe that we will not learn very much from reviewing it. But, in fact, we can learn a great deal from examining these so-called "natural deaths."

To illustrate why it is important to review even natural deaths, consider that the forensic authority may focus on the very last stage(s) of the death without looking for or taking into account events leading to these last stages. For example, the last stages of death in an individual with diabetes may have been high blood sugar, followed by a heart attack. High blood sugar and heart attacks are not uncommon events in diabetes in prison as well as in the community. Hence, the forensic authority may categorize the death as natural. However, it is possible that the individual's blood sugar was high because the prison failed to administer any insulin to the patient over several days. With that added information, some forensic authorities would instead choose to categorize such a death as an accident or even a homicide.[3]

Another example could involve a person who experienced a heart attack, but whose symptoms were ignored by the prison officer on duty until the person died. In both of these examples, but for the inactions of the prison health care staff or security staff, the individual would still be alive. The connection between the bad actions of prison staff and a "natural" death can be even more buried when those actions occurred months or years before the death. A common example is an individual who dies of cancer long after the prison doctor ignored the individual's obvious symptoms.

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While "natural" deaths are the most common reason an OB might decline to conduct a review, other categories can also mislead the OB. For example, deaths from illicit drug overdose are becoming more common and are usually categorized as "accident," which might not trigger a DR-SI. However, a more thorough review of a hypothetical death that included:

- a conversation with the individual's attorney (who revealed that two days before the death, she met with the individual and informed him that he was likely to receive a long sentence), and
- a conversation with the individual's roommate (who revealed that the individual had been depressed for the last two days, and rarely got out of bed), and
- an examination of the security log (that showed the individual suddenly stopped eating his meals), and

[3] The manner of death "homicide" does not convey any criminality. It simply means that *but for* the actions of another human being, the individual would still be alive.

- a review of recordings of conversations the individual had with his wife (during which he expressed that he didn't think he could survive a long prison sentence),

would have clearly indicated that the death was a suicide, not an accident. If the OB had accepted without question that the death was accidental and declined to conduct a DR-SI, it would not have the opportunity to identify failures in the prison's suicide prevention system.

Similarly, accidental deaths from overdoses provide irrefutable evidence that drugs are entering the prison, an issue that is surely of interest to any OB examining the need for system improvements.

5. Fixing the system…permanently

Our purpose in all the work I've described above is to fix problems with the prison's system of care to prevent future harm. To achieve this goal, the OB needs to follow three critically important principles during the DR-SI.

First, whenever the OB discovers an error during a DR-SI, the OB needs to dig "below the surface." Indeed, the errors that the review initially uncovers are what are called "active" errors. They are the mistakes that are obvious at first glance. For example, during a DR-SI, the OB's review team learned that an individual died because a nurse administered the wrong medication and that the nurse was heavily intoxicated with alcohol at the time of the error. Certainly, the nurse must be held accountable (which likely was already addressed by the accountability-focused death review). But the nurse's action is only the active end of one or several deeper, or "latent," system problems. Thus, even if the nurse is fired, a similar error could recur. The DR-SI team needs to look deeper: How is it that none of the nurse's co-workers ever noticed that she sometimes came to work drunk, and if they noticed, what is the problem with the work culture that none of them notified a supervisor? Digging even further, the team needs to examine whether there are flaws in the recruitment and vetting process that allowed the nurse to be hired in the first place. This digging ("root-cause analysis") may uncover one or several root (latent) causes of the active error which, if not fixed, would allow the error to recur.

Second, the DR-SI should not be limited to examining errors which definitely caused (or contributed to) the death. Causation is important in certain death reviews. For example, in the criminal part of a death review, we cannot hold an employee liable for even an egregious error, if that error did not play a role in the death. Not so in the DR-SI. Here, the OB should be interested in *any* serious error it discovers, because the goal of the review is to prevent future harm; though the error was not fatal this time, it could lead to death the next time.

Third, the recommendations that emerge from a DR-SI must result in *sustainable* system change. For example, issuing an email or giving a directive at the next staff meeting, with instructions to avoid the error, is fine. But it will not result in sustainable change beyond the next few weeks or months, after which the employees who received the instruction have moved out of their positions or forgotten the emails. For a system change to be sustainable, the prison must make improvements not only to policies,

procedures, and training curricula but also take steps to embed those changes and monitor their effectiveness.

In summary, in cases of health-related deaths in custody, it is important for OBs to conduct death reviews that look beyond accountability ("whose fault was the death"). Such reviews use a variety of rich information available in the prison to "dig" below the surface to find the underlying system problems that contributed to the death, or might contribute to a future death. Having found those problems, the OB should then recommend improvements that result in lasting system change.

References

The following may be helpful to learn more about death reviews in carceral settings:

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What we learned when we looked at 300+ deaths in New Jersey prisons

By Terry Schuster

Terry Schuster

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Terry Schuster is the New Jersey Corrections Ombudsperson. He directs an office that inspects state prisons for health and safety issues and investigates complaints of mistreatment from incarcerated people and their loved ones. Terry is an attorney and criminal justice policy expert. Before being appointed to this role, he worked in various positions focused on sentencing policy reform and juvenile prison oversight.

In my first few months as Ombudsman for the New Jersey prison system, I met a grieving mother whose son had died by suicide in an isolation cell just a year before he was scheduled to be released. I could feel the weight of this loss to his mother. She carried around a photo of him. She was so disappointed by the lack of information she got from the prison administrator about what happened. “How could this happen?” she kept asking.

Eventually, her mistrust of the prison leadership led her to wonder if her son was actually killed and if officials were just trying to make it look like a suicide. A lack of information surrounding deaths behind bars builds distrust, even paranoia.

I believe it likely was a suicide, though my office was not one of the investigative bodies that looked into his death. When we were able to review a large sample of deaths in custody, we saw clusters of suicides in disciplinary units like the one her son was held in for several years.

Historically, in New Jersey, the prison system did not issue public reports about deaths. When a person in custody died, their next of kin was notified, but given no information about what happened. They could follow up months later for a medical examiner’s report, which may still leave them with questions: Who

found him? How long had he been suffering? Was he getting treatment? Why didn't someone call me sooner?

A prison oversight office can bring transparency into a part of government that operates outside of public view. It can also contextualize individual terrible events within a landscape of data and trends.

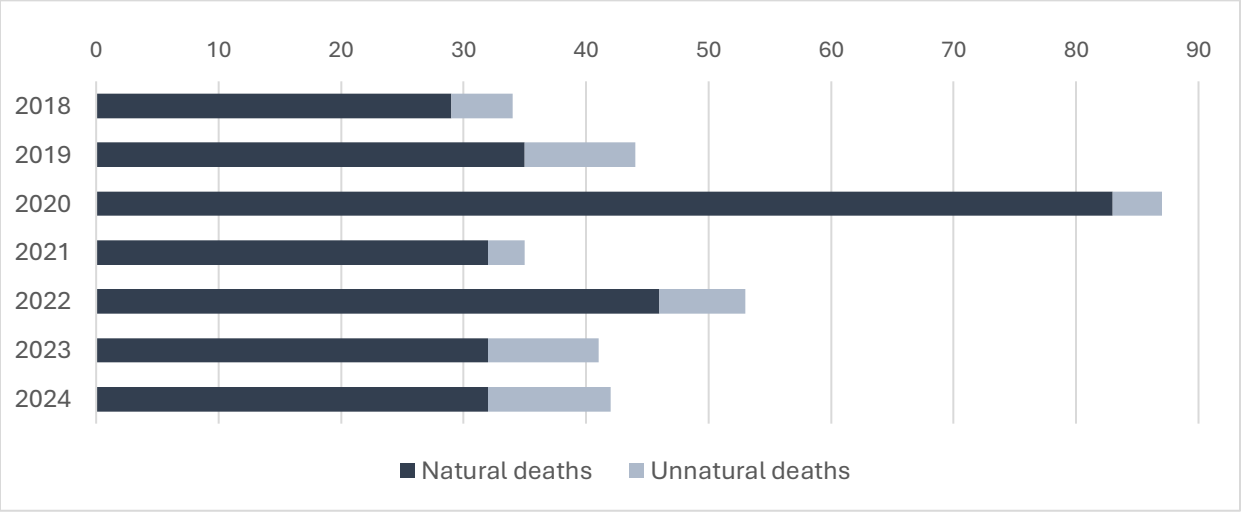
The Office that I lead had no previous experience monitoring deaths in custody, but a new statute gave us clear authority to do so. The topic felt heavy. Loaded. We didn't want our first foray into the subject to assume wrongdoing on the part of the state prisons or to put the prison commissioner on the defensive. To get our bearings, we needed to answer big, but simple, questions.

How many people have died in custody? From what? And where?

By starting with big questions, we hoped our analysis would help policymakers see the bigger picture, ask more targeted questions, and make informed decisions about how to prevent avoidable deaths.

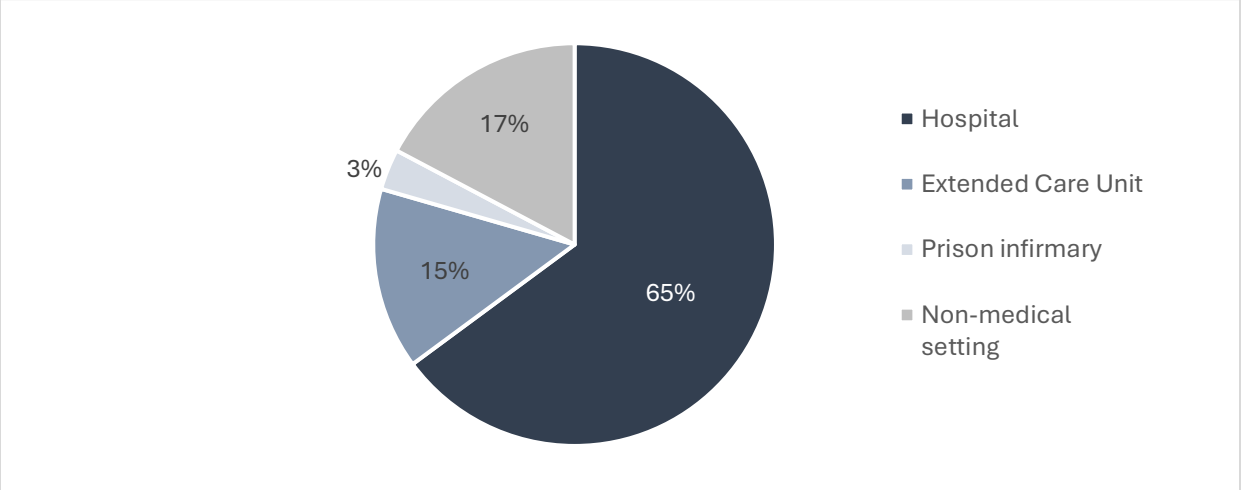
We worked with the state medical examiner to identify a full list of people who died while in the custody of the New Jersey Department of Corrections between 2018 and 2024. A total of 336 people. About half of these deaths were related to heart disease or cancer. A little less than 50 people died, on average, each year in our state prisons, with the exception of 2020 when the COVID-19 pandemic led to double the average number of deaths in custody.

Figure 1: Total deaths in New Jersey prisons, by year, 2018-2024



Nearly half of the prison deaths took place at a prison in the southern part of our state, which is the only one outfitted with an Extended Care Unit for acute and end-of-life care. More than 80% of prison deaths occurred in a medical setting, counting the Extended Care Unit, other prison infirmaries, and hospitals.

Figure 2: State prison deaths in a medical versus non-medical setting, 2018-2024

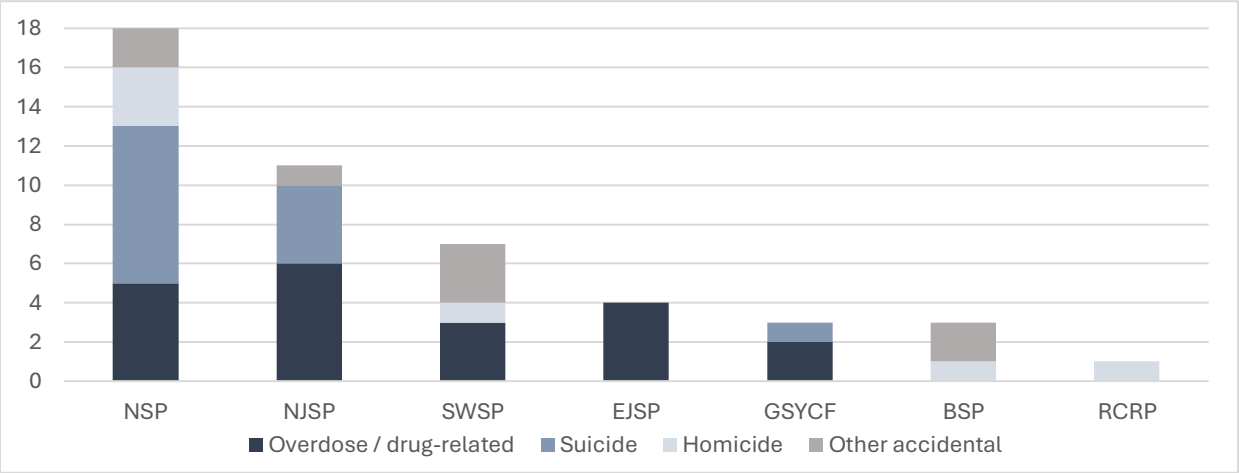


One finding that generated interest among journalists was that even though the incarcerated population was significantly reduced during our 7-year study period from more than 19,000 in 2018 to less than 13,000 in 2024, the overall rate of deaths went up. The prison system's medical director offered his own analysis in response, providing interesting context. He noted that as the prison population shrunk, the average age increased, and the population in 2024 had a higher concentration of specialized medical needs compared with the prison population in 2018.

Roughly one in every seven deaths in New Jersey prisons was not a natural death, including 20 overdoses and other drug-related deaths, 13 suicides, 6 homicides, and 8 accidental deaths. We learned that more than half of the suicides were people being held in a disciplinary housing unit. Another trend that practically jumped off the page was that three-quarters of the unnatural deaths were happening at just two facilities.

We learned that more than half of the suicides were people being held in a disciplinary housing unit. Another trend that practically jumped off the page was that three-quarters of the unnatural deaths were happening at just two facilities.

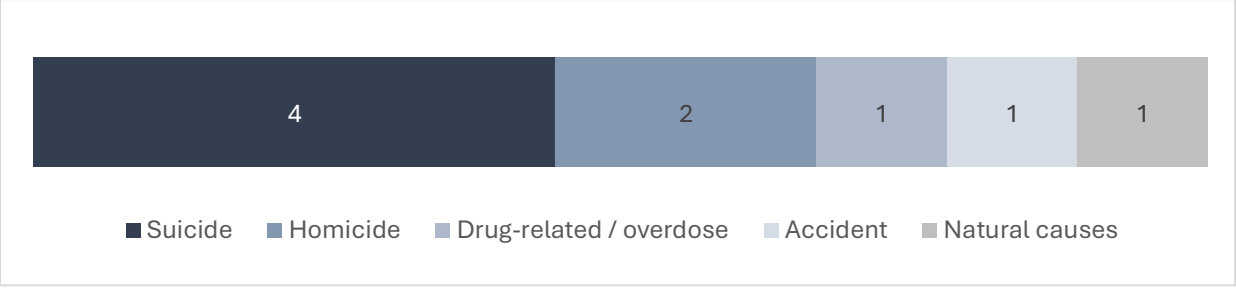
Figure 3: Deaths from unnatural causes, by facility, 2018-2024



The grieving mother I mentioned at the beginning of this article had learned that her son committed suicide at Northern State Prison (labeled NSP in the graph above). What we learned from this data analysis was that Northern was the site of more suicides than any other prison and had as many homicides as every other prison combined. Any policymaker looking at this report should naturally ask: What's happening at Northern State Prison?

Using dates of birth, we were able to see that the age at which people in New Jersey died in prison mirrors the national data on deaths in U.S. state prison facilities. About 18% of people who died in New Jersey prisons were under the age of 45. Another 18 percent were ages 45 to 54, and the remainder—roughly two-thirds—were 55 years old or older. Some of the most tragic deaths in custody involved very young people. In our state, there were nine people aged 25 or younger who died in prison between 2018 and 2024. Eight of the nine were ruled by county medical examiners to be deaths by unnatural causes.

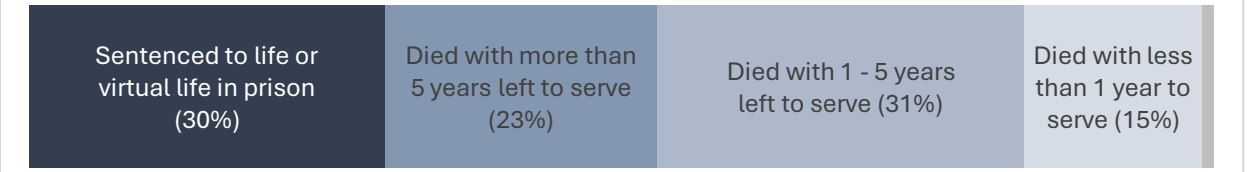
Figure 4: Deaths of incarcerated young people (age 25 and younger) in New Jersey prisons, 2018-2024



With a bit more data-gathering, we were able to look at how much time people had left to serve in prison when they died. Less than a third of people who died between 2018 and 2024 were sentenced to life in prison or what we referred to as a "virtual life" sentence (one with a projected release at age 90 or older).

One data point that sticks with me after this analysis, because it just seems so unfortunate, is that 15% of deaths (50 people during our sample period) died with less than one year left to serve in prison.

Figure 5: Deaths in New Jersey prisons, by time remaining until release from prison, 2018-2024



Note: 1% of deaths in New Jersey prisons were people not serving New Jersey state sentences (jail holds or prisoners from out-of-state).

So what came of this research? Our findings were interesting but not groundbreaking. We published a report in December 2025, and one immediate outcome was that the New Jersey Department of Corrections agreed to begin publishing annual data on deaths in custody starting where we left off. That's a big deal—a prison oversight activity that led the prison system to be more transparent with data.

It has also led me and my staff to ask more interesting questions when we learn of a death in custody. In just the last several months, for example, there have been three homicides in our state prisons. Because we know how rare homicides are, it's clear that three is an unusually high number. When we examine those homicides, we see that two of them occurred at the prison we know has the highest number of unnatural deaths. As we looked more closely at those two, we saw that not only did they both occur in the same housing unit, but they occurred on the same *floor* of the same *wing* of that housing unit. We're able to ask better questions about what went wrong in these two cases, and what's happening on that housing unit, because we already have a baseline understanding of the landscape of deaths in custody.

Similarly, we know that deaths of young people in prison are relatively rare. Already this year, however, one homicide and one suicide have involved young people in custody. For each of them, we're now asking deeper questions about their housing assignments. Why would a person classified as minimum security be housed with a cellmate who has a long history of fights and violence? Why would someone who has attempted suicide several times be placed in a room with open bars where he could attempt to hang himself?

Prompted by complaints from the incarcerated population, we have also begun looking into some deaths deemed natural, in which the on-site emergency response may have been inadequate. We reviewed the body-worn camera footage of officers who responded to a person who passed out in the yard after exercising—a death that was later determined by the medical examiner to be asthma-related. In the video, you can hear a bystander shouting, "he has asthma," and the officers repeating it back, but when the nurses arrived, that information was not shared with them. Twenty minutes pass before the nurses

administer oxygen, and during that time, they give three Narcan doses, assuming the man overdosed. Setting aside the question of whether this person would have survived if the emergency response were different, this is certainly a case the prison agency can learn from, and we're in a position to help prevent similar deaths in the future by sharing our observations and identifying areas where emergency responses could improve.

We've now seen video footage in multiple cases where prison staff responding to a scene are not performing CPR appropriately, which has led us to add a CPR training audit to each of our prison inspections.

We've now seen video footage in multiple cases where prison staff responding to a scene are not performing CPR appropriately, which has led us to add a CPR training audit to each of our prison inspections.

Beginning with a fairly simple data analysis of prison deaths has allowed us to do more sophisticated analysis of individual deaths moving forward, and it's a great place to start for other oversight bodies tasked with monitoring deaths in custody. It has signaled to the incarcerated population and their families that we're an office they can approach with concerns. And it has motivated the prison system's leaders to be more proactive in what they share publicly and what they share with us.

Finally, building on our momentum, one of the next frontiers I hope to explore involves how prison leaders deliver the news of a death to a family member, and what sort of care and support is offered to the person's cellmate and friends who may also be grieving—softer skills that build trust and help people navigate traumas. If we can generate real discussion and policy reform around these soft skills, I believe we can help broaden the safety and security lens that prisons often operate within to include the types of interactions that actually make people feel safe.

Deaths in Custody in New York's Prisons: Oversight, Shifting Perceptions, and the Case for Sustained Monitoring

Sumeet Sharma

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An Increase in Prison Mortality: 2024 and 2025

In 2024, 143 people died while incarcerated in New York State's prisons, representing a 34% increase from the 107 deaths recorded in the previous year. The total for 2024 marked a five-year high, surpassing the 137 deaths recorded in 2021, at the height of the COVID-19 pandemic. Of these 143 individuals, 43 were under the age of 40, a staggering 30% of the total, showing a sharp rise year over year and marking a peak for the previous five-year period. In 2024, deaths by suicide in New York's prisons increased by 108% (rising from 12 in 2023 to 25 in 2024), a figure well above the average of 13 annually between 2004 and 2024.[1]

While 2025 brought an improvement in both the number of deaths at 128 and deaths of individuals under the age of 40 at 23%, the statistics remain historically high compared to the pre-2024 average. Suicides also declined during this period, with 12 reported deaths by suicide over the course of the year.[2] [3]

In New York, the attention paid to these deaths since December 2024 has shifted the landscape of justice, reform, and accountability while underscoring the value of ongoing, independent oversight to ensure these initial reforms are fully implemented and translated into lasting systemic change.

Crisis in New York's Prisons: Murders of Incarcerated Individuals by Correctional Officers and a Wildcat Strike

Robert L. Brooks, Sr., was a 43-year-old man from Rochester, New York. Sentenced to a twelve-year term in 2017, he was in his eighth year of incarceration at Mohawk Correctional Facility in Rome, New York, and would have been eligible for parole in July 2026. On December 9, 2024, Brooks was transferred to Marcy Correctional Facility in Marcy, New York, about 15 minutes away from Mohawk.

This emergency transfer was initiated after Brooks was assaulted at Mohawk; he arrived at Marcy already suffering from visible facial bleeding and trauma. However, instead of receiving immediate medical intervention, he was taken to the Marcy infirmary and subsequently beaten by Marcy security staff while medical personnel remained outside the room, resulting in his death. The assault on Brooks at the Marcy facility was inadvertently captured on body-worn cameras and released to the public by the State's Attorney General.[4]

In 2025, Messiah Nantwi, a 22-year-old from Harlem, was incarcerated for less than a year at Mid-State Correctional Facility, located adjacent to Marcy Correctional Facility. On March 1, 2025, Nantwi was beaten to death in his cell by a Correctional Emergency Response Team (CERT) at Mid-State. His death occurred less than three months after the death of Brooks.[5] This time, however, there was no video that captured the assault.

The deaths of Robert Brooks and Messiah Nantwi spotlighted a culture of impunity and brutality long overlooked due to a lack of documentation or acknowledgment from leadership, laying bare the systemic deficits in transparency, oversight, and accountability surrounding deaths in prisons. The brutality shown in the death of Robert Brooks, captured on body-worn cameras that staff incorrectly assumed were turned off, underscored the inherent value of transparency. The extraordinary and unprecedented public release of that footage became the platform for significant change in the following year.

Following the death of Robert Brooks, a wildcat strike, an illegal, unsanctioned walkout executed by workers without the authorization or approval of their union leadership, by correctional officers crippled operations in 38 out of 42 facilities. The unsanctioned walkout, which began the same week officers were being indicted for the Brooks murder, was driven by long-standing staff grievances, including chronic understaffing, the widespread use of mandatory overtime, and union opposition to the statutory limits placed on solitary confinement by the passage of the HALT Act in 2021.[6] Enacted to bring New York in line with international human rights standards, this law strictly limits the use of isolated, segregated confinement to a maximum of 15 consecutive days and completely bans it for vulnerable populations.[7]

Messiah Nantwi's death occurred two weeks into the resulting work stoppage. The shutdown left civilian staff and the National Guard, deployed following a declaration of a state of emergency due to the strike, to facilitate basic operations. Meanwhile, incarcerated individuals faced severely restricted access to out-of-cell time, food, and medical care. By exacerbating already problematic conditions, the strike further exposed the prisons' tumultuous state to the public.[8]

Layered Investigations and Official Reporting

While New York purportedly has measures in place to investigate, report on, and track fatalities, the state agencies responsible for fulfilling these functions, including the State Commission on Correction (SCOC), State Attorney General's Office, and Department of Corrections and Community Supervision (DOCCS), each lacked either the independence, resources, or political will to effectively shed light on prison deaths.

Under established state protocols predating the high-profile deaths at Marcy and Mid-State, when someone dies in a New York prison, DOCCS (the state agency that operates the prisons) is required to take immediate steps to report and investigate that death. Among these steps, a clinician must officially pronounce the death, and staff must immediately file an Unusual Incident Report with the DOCCS Communications Control Center to alert the State Commission of Correction (SCOC) within six hours. Staff at a facility are also required to notify the state police or local law enforcement if a homicide or suicide is suspected, inform a County Coroner or Medical Examiner for a mandatory autopsy, and respond to inquiries from the legally recognized next of kin.[9]

Within 10 days of the incident, the facility's medical director must submit a comprehensive follow-up report to the SCOC detailing the individual's recent medical history and the circumstances leading up to the death. DOCCS' Office of Special Investigations (OSI) is also responsible for determining whether a death is caused by an act or omission of a peace officer or directly caused by a peace officer, which includes prison security staff. If OSI determines any level of involvement by security staff, it must notify the State Attorney General, who then holds criminal jurisdiction to investigate the incident as an officer-involved death.[9]

Once a death is reported to the SCOC, the agency's Medical Review Board is responsible for investigating the circumstances surrounding the death and for making recommendations to prevent recurrences related to the delivery of medical care. The SCOC may also conduct an independent autopsy and forensic examination to determine the official cause and manner of death, regardless of whether a local county coroner or medical examiner has already conducted a review. Despite this broad authority, the SCOC historically conducts medical reviews for only a third of prison deaths, and it remains unclear when the commission last initiated an independent autopsy. The passage of the Prison Reform Omnibus Bill of 2025 strengthened the authority of the SCOC to investigate the deaths and gave it more tools to do so.[10]

The Role of Independent Oversight

The Correctional Association of New York, while lacking the authority to conduct postmortem investigations or issue formal determinations on manners of death, fulfills a distinct statutory role by aggregating data, monitoring facility conditions, and providing independent public reporting to drive structural policy reform. This independent oversight proved critical in providing the public insight into the murders of Robert Brooks and Messiah Nantwi.

CANY, under §146 of New York's Correction Law, is charged with visiting and examining the state's correctional facilities to identify and report on prison conditions, the treatment of incarcerated individuals, and the administration of policy promulgated by the executive and legislature. The organization's unique access to prisons and its structural independence from the state form the foundation of its oversight capacity. Through the dissemination of data, thorough monitoring reports, targeted recommendations to lawmakers, and engagements with key stakeholders, this independent oversight ensures that prison conditions remain a focal point of public and legislative consciousness.[11]

In October 2022, CANY conducted monitoring at both Marcy and Mid-State as part of its legally mandated oversight of New York's State Correctional Facilities. In July 2023, CANY released a report containing findings and recommendations following its monitoring visit to Marcy.[12] In it, CANY noted that during interviews, 80% of incarcerated people reported having witnessed or experienced abuse by staff, and nearly 70% reported racial discrimination or bias. According to one person interviewed by the organization, "Physical abuse is rampant; the CO told me when I got here, 'This is a hands-on facility, we're going to put hands on you if we don't like what you're doing.'" Another stated that staff "brag and intimidate us about the number of people they've beat or sprayed." On the second day of the monitoring visit, incarcerated individuals reported that security staff had announced the prior evening that anyone speaking with CANY representatives would face retaliation. CANY called upon DOCCS' Office of Special Investigations and the New York State Inspector General to investigate these serious and pervasive allegations.[13]

On the second day of the monitoring visit, incarcerated individuals reported that security staff had announced the prior evening that anyone speaking with CANY representatives would face retaliation.

Shortly after this report, CANY released another report with findings and recommendations following its monitoring visit to Mid-State. In it, CANY showed lower rates of verbal, physical, or sexual abuse at Mid-State than at Marcy (56% of the population at Mid-State reported having witnessed or experienced abuse by staff), and reported racialized abuse was lower (at 8%). Nonetheless, the report detailed significant allegations of staff misconduct and systemic retaliation for filing grievances.[14]

During a follow-up visit to Mid-State in January 2025, and as detailed in a subsequent CANY public statement, several incarcerated individuals recounted specific incidents of ongoing violence by correctional officers, and many expressed intense fear of retaliation for speaking with oversight monitors. They also described a general lack of accountability throughout the facility, resulting in fundamental breakdowns in trust and the functioning of essential services, including medical care. The statement pointed to an "overall deterioration of conditions."[15]

CANY also released a set of recommendations to 'Improve Safety, Institutional Culture, and Living & Working Conditions' within DOCCS Facilities in the year following the visits to Marcy and Mid-State, calling for the state to expedite the installation of fixed cameras, expand the operational use of body cameras, and require DOCCS to notify the public of a death in a correctional facility through formal announcements and its website. Additionally, CANY urged the state to work with partners inside and outside of government to address the systemic operational issues that allow brutality to flourish, collaborating with entities such as the State Office of Mental Health (OMH), established research partners, and organizations focused on culture change. The recommendations emerged from sustained oversight and a nuanced understanding of correctional operations built across thousands of interviews with incarcerated individuals and extensive communication with key stakeholders, such as state legislators, staff unions, and advocates for directly impacted individuals.[16] [17]

Taken as a whole, the two reports highlight a disparity between limited government reporting on prisons and the transparency provided by independent oversight. They also illustrated the gap between recommended actions and the political will required to implement necessary changes. That gap narrowed following the murders of Brooks and Nantwi, however. In a shift from prior years, sustained independent reporting combined with media coverage of the high-profile incidents - including the publicly released video of the assault of Robert Brooks and the illegal corrections officer strike - mobilized broad public support for reform. Due to these reports, lawmakers and department officials could no longer deny the rampant violence and misconduct at Marcy, Mid-State, and other prisons.[18]

A Turning Point: Reforms from the Governor and Legislature

New York Governor Kathy Hochul visited the Marcy facility following Brooks' death. Upon leaving the prison, she announced public support for certain recommendations CANY had issued in 2023 and 2024, and provided funding to bring those initiatives to fruition in the following year's budget. Governor Hochul committed $400 million to accelerate the installation of fixed cameras throughout facilities and $18.4 million to expand the use of body-worn cameras. Additionally, she pledged to restructure the DOCCS Office of Special Investigations so that it could expand its review of complaints, partner with external organizations to drive culture change, and conduct a safety analysis. The Governor also announced a $2 million investment in CANY, noting the organization's monitoring activities are "a critical step in providing independent and ongoing concerns and solutions to the agency."[19] The Governor's proposed funding was later bolstered by an additional $1.127 million appropriation from the State Legislature.[20]

In June 2025, the legislature passed its own package of reforms through the "Omnibus Prison Reform Bill," which strengthened transparency, oversight, and accountability measures in state prisons. The omnibus package codified several long-standing CANY recommendations, including a new requirement to provide immediate notice to next of kin and the public following any death in custody, joining 28 other states with similar public notification laws. It also mandated comprehensive camera coverage in all correctional facilities and guaranteed that the State Attorney General would have immediate, unredacted access to footage in the event of a fatality.[21] [22]

Importantly, the legislation also strengthened the SCOC, requiring the agency to conduct a comprehensive study of prison deaths within the year. This was in addition to resources provided to the commission in the state's 2025 budget, which doubled the entity's funding to scale up its on-site monitoring, investigations, and medical reviews. Finally, the bill expanded CANY's statutory oversight powers, reducing the mandatory facility notice period for visits from 72 to 24 hours and granting the organization direct access to internal datasets that were previously available only through Freedom of Information Law (FOIL) requests. [23]

2026 and Beyond: Bridging the Gap Between Reform and Implementation

Deaths in custody serve as a critical barometer of a correctional system's integrity, offering a stark audit of whether the state is upholding its legal obligation to provide for the safety and dignity of those in its care. Aggregate data on prison deaths tracks institutional trajectories over time, while isolating specific causes of death can show underlying systemic deficiencies driving those trends.

Aggregate data on prison deaths tracks institutional trajectories over time, while isolating specific causes of death can show underlying systemic deficiencies driving those trends.

Year-to-date, 2026 has the most in-custody deaths of any year since at least 2020, including during the COVID-19 pandemic. According to data CANY received from the SCOC, 57 incarcerated individuals died in New York's prisons between January 1 and April 30, 2026.[1] This sobering trend underscores the necessity of independent oversight, which serves to verify that facilities are complying with established policies and maintaining the adequate treatment and living conditions necessary to prevent further loss of life. The passage of the Omnibus Prison Reform Bill and changes announced by the Governor in 2025 were watershed reforms, but they can only be effective if their implementation is consistently and independently monitored.[24]

The massive project of installing fixed cameras systemwide and ensuring the consistent use of body-worn cameras requires continued monitoring to ensure that compliance matches the reality on the ground. Simultaneously, the state's prison system continues to suffer from the compounding effects of

low staffing levels, inadequate medical care, and a now four-year struggle to fully implement the HALT Solitary Confinement Law.[25] [26]

Ultimately, the arc of reform in New York demonstrates that independent oversight is not a one-time event, but a continuous practice. Without an objective view, the state's lawmakers and the public cannot effectively reconcile the varied perspectives of department administration, staff unions, incarcerated people, and advocates to address ongoing institutional crises. To reduce unnecessary deaths and know the true causes of unanticipated deaths, policymakers and the public must have a comprehensive understanding of the operational reality inside prisons today.

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The Value of Oversight: Investigating Deaths in New Zealand Prisons

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Mā te titiro me te whakarongo ka puta mai te māramatanga
By looking and listening, we will gain insight

Background

New Zealand has a population of around 5.36 million and, as of 2 July 2026, the prison population was 11,190 people in 18 prisons. Māori (New Zealand's indigenous people) are over-represented, comprising around 52% of the prison population, compared with 17.5% of the general population (Statistics NZ, June 2025). Seventeen of the 18 prisons are public, three of which are for women, and one men's prison is privately operated.

The Office of the Inspectorate *Te Tari Tirohia* is a critical part of the independent oversight of the New Zealand Corrections system and operates under the Corrections Act 2004 and the Corrections Regulations 2005. Inspectors of Corrections have extensive powers under section 29 of the Corrections Act 2004. The Inspectorate, while part of the New Zealand Department of Corrections *Ara Poutama Aotearoa*, is operationally independent to ensure objectivity and integrity.

The value of prison inspections in closed environments

The Inspectorate conducts a programme of prison inspections (around four every year) which provide a 'window into prisons,' giving early warning of emerging risks and challenges, and highlighting areas of innovation and good practice that other prisons are encouraged to follow. The inspections are guided by Inspection Standards to deliver independent and objective assessments of the treatment of and conditions for prisoners in New Zealand.

Standard 44 requires that 'Prisoners at risk of self-harm or suicide are supported in a therapeutic environment with trained staff who are resourced to meet their individual needs.'[1] This describes the standards of treatment and conditions we expect a prison to achieve. Inspectors consider the following Indicators when assessing the prison's performance:

- All staff are trained in identifying self-harm and suicidal behaviour, and suicide prevention.
- Prisoners at risk of self-harm are placed in an environment where they can easily access the clinical support they need and a purposeful regime with meaningful activities and regular engagement with other people.
- All staff engage in a supportive and constructive way with prisoners in mental crisis, in a culturally appropriate way.
- Prisoners being managed in an alternative or restrictive regime due to their risk of self-harm are consulted and informed about their care, including how to return to a standard regime.
- Any prisoner being managed in an alternative or restrictive regime due to their risk of self-harm should be visited daily and as frequently as is necessary by a health professional to monitor physical and mental health.
- Responses to risks of self-harm and suicide are gender-specific and culturally appropriate.

Inspection reports, including findings, are publicly released and placed on the Inspectorate's website. Prison general managers are expected to provide action plans to address the findings of each report and the Inspectorate monitors each site's progress.

The death in custody investigation process

Each year around 24 people die in New Zealand prisons and, pursuant to a memorandum of understanding between the Chief Executive of the Department of Corrections and the Chief Ombudsman, the Inspectorate conducts a comprehensive investigation into every one of these deaths. Around 60 percent of deaths are from natural causes (i.e. have a medical cause), and 40 percent are categorised as 'unnatural' (which includes suspected suicide, homicide, accidental or other non-natural deaths). In the past three years, there have been four homicides in New Zealand prisons – three where the alleged perpetrator shared a cell with the deceased person. These homicides are investigated separately by New Zealand Police.

Inspectorate investigations examine the circumstances of each death, including the natural deaths, to understand what happened and identify any matters arising from the prisoner's management in prison.

Investigations are conducted by Inspectors from the Inspectorate (Regional Inspectors who have custodial expertise, and Clinical Inspectors who are registered nurses), because health and custodial issues often intersect. Broad terms of reference and statutory powers enable Inspectors to widely investigate all aspects of a deceased person's management while in Department of Corrections' custody. The Chief Inspector writes to the family of each person who has died to explain the Inspectorate's role in investigating the death and reporting to the Coroner. Inspectors are available to family members to discuss the investigation process.

Once the report has been drafted, there is an extensive quality assurance process. This includes comprehensive scrutiny by the Chief Inspector and legal review by the Inspectorate's Principal Legal Adviser.

The draft investigation report, with findings and recommendations, is provided to the Department of Corrections under a natural justice process, generally with four weeks permitted for a response. This allows the Department to check for factual accuracy and respond to the recommendations. The Department provides a formal letter in response. This letter is appended to the report, which is finalised and provided to the Chief Executive, the Coroner, and the Ombudsman.

Our reports are not released publicly, as in some jurisdictions, out of respect for the privacy of the individual deceased prisoner and also because of Coroner's Act restrictions on publications of certain matters. The family of the deceased person can request a copy of the report from the Coroner. Under the Coroners Act 2006, every "death in official custody or care" is reported to the Coroner. Coroners hold an inquiry (either "on the papers" or in a formal hearing (inquest) in a Coroner's court) about how a person died. Coroners issue findings and can make recommendations or comments that might prevent a similar death in the future. The Coroner rules on the cause of death, and only the Coroner can rule a death as a suicide.

Deaths from assumed natural causes

With the growing and ageing prison population, the Department of Corrections can expect to respond to an increasing number of prisoners who die from terminal illnesses and the diseases of old age. In these cases, death in custody investigations focus on whether the access to, adequacy of, and provision of health care met the required standards.

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Prevention and education focused thematic investigations for assumed unnatural deaths

As well as investigating individual deaths, the Inspectorate has undertaken thematic investigations into suicide and self-harm, and separation and isolation, to gain wider insights into the prison environment and management of prisoners. These are prevention and education focused reviews, aimed at providing insights and recommendations to the Department of Corrections which can help drive change and improvements.

In June 2023, the Inspectorate released a thematic report, *Separation and Isolation: Prisoners who have been kept apart from the prison population*.[2] The report noted: "The effects of segregation, solitary confinement, isolation, separation, and any other form of restrictive imprisonment, however this is described, demands the closest of scrutiny by oversight agencies" (p.3). Quoting the World Health Organisation's report, *Preventing Suicide in Jails and Prisons*,[3] the Inspectorate noted: "The majority of suicides in correctional settings occur when an inmate is isolated from staff and fellow inmates. Therefore, placement in segregation or isolation cells for necessary reasons can nevertheless increase the risk of suicide" (p.16). [4]

The report recommended that "corrections must recognise the profound isolation experienced by segregated and at-risk prisoners, including that many are likely to be subject to solitary confinement as that term is defined by the Mandela Rules," and "do more to mitigate the extent of the isolation experienced by such prisoners, especially where that isolation is beyond 15 days." These recommendations (and five others) were accepted by the Department, leading to its first acknowledgement that solitary confinement and, in some cases, prolonged solitary confinement, was occurring in New Zealand. The Department said the report "outlined for Corrections a compelling case for change" and agreed to "work across Corrections to develop a long-term, system-wide plan for enduring change" (p. 102).

Our companion report, *Suspected Suicide and Self-Harm Threat to Life Incidents in New Zealand Prisons*,[5] published in February 2024, had significant areas of commonality; those separated or isolated whilst in prison are often involved in serious self-harm incidents or, sadly, die by suspected suicide.

The genesis for this work was our concern that the number of suspected suicides and serious self-harm threat to life incidents in New Zealand was increasing. Given that individual reports of deaths in custody are not published, we thought it imperative to examine and report on this systemic concern publicly. The *Suspected Suicide and Self-Harm* report acknowledged: "There are no easy solutions when it comes to suicide and self-harm prevention in prisons. However, there are practices and interventions that can help to save lives and reduce self-harm incidents. Corrections has a duty of care to all people in prison and must do everything it can to identify and mitigate the risk of suicide and self-harm" (p.17).

The report noted that 62% of prisoners who died by suspected suicide during the five-year review period (1 July 2016 to 30 June 2021, when 29 people died of suspected suicide) did so within their first 100 days in prison; 38% were in prison for the first time.

The report found "remand prisoners experience many known risk factors for suicide and self-harm, including social isolation, restrictive regimes, uncertainty over court outcomes, alcohol and other drug withdrawal and lack of purposeful activity" (p.9).

Quoting the *Comorbid Substance Use Disorders and Mental Health Disorders Among New Zealand Prisoners*,[6] the Inspectorate's thematic report[7] noted: "Prisoners have a higher incidence of known risk factors for suicide and self-harm than people in the general population. For example, nearly all (91%) people in New Zealand prisons have a lifetime diagnosis of a mental health or substance use disorder, compared to 40% of people in the general population. Prisoners with a mental health disorder (such as an anxiety or mood disorder) have the highest rates of recent or lifetime suicidal behaviour; almost two thirds (62%) of people in New Zealand prisons meet the diagnosis for either a mental health disorder or a substance use disorder" (p.18).

As of July 2025, prisoners aged 65 years and older made up 4% of the New Zealand prison population, of whom 98% were men and 2% were women. Those 55 years and older made up 11.8% of the population. While older people in prison are often defined as those aged 65 years and over, it is important to recognise that many people in prison experience earlier onset of ageing, with complex health and disability needs emerging well before this age. This is particularly relevant for Māori, who face significant inequities in health outcomes.

While prisoners can apply to the New Zealand Parole Board for compassionate release if they are seriously ill and unlikely to recover, the reality is that many elderly prisoners lack family support outside prison and struggle to find suitable accommodation to enable release.

Prisoners with a terminal illness should have an end-of-life care plan, just as they would from their primary health carer if they lived in the community. The plan is intended to ensure that people who are dying can express what is important to them about their care and can live as comfortably as possible until they die.

These issues were discussed in our August 2020 thematic report, *Older Prisoners: The Lived Experience of older people in New Zealand Prisons*.[8]

The role and value of oversight in the investigation of deaths in prisons

As an oversight entity, the Inspectorate is one of the few jurisdictions which conduct death in custody investigations, prison inspections and thematic investigations (such as those outlined in this article) alongside our other statutory functions including responding to complaints.

The insights from this broad range of work undertaken by the Inspectorate provide us with a rich source of information to guide our decision-making about findings and recommendations that will make a meaningful difference to Corrections' practices, policies, and procedures. Our determination, as an Inspectorate, is to deliver a reactive, preventive, and educative approach to oversight.

Without a 'frank and fearless' independent oversight mechanism, many of these insights may be missed, along with opportunities to improve the environment, conditions, and management of those who are imprisoned in New Zealand.

The insights from this broad range of work undertaken by the Inspectorate provide us with a rich source of information to guide our decision-making about findings and recommendations that will make a meaningful difference to Corrections' practices, policies, and procedures.

And finally, but importantly, to acknowledge New Zealand's indigenous Māori population, who are over-represented in the prison system, the Inspectorate was gifted a karakia (traditional Māori incantation or prayer), which is included in the final report for each Māori prisoner who dies in custody.

Karakia Waerea

Waerea te Pāpā Waerea te whare mauhere Kia wātea (wātea!)	Clear the ground Clear the prison To free any restriction
Unuhia, te ngao a Tū Unuhia te ngao a Whiro Kia wātea (wātea!)	Withdraw the energy created by Tūmatauenga Withdraw the energy created by Whiro To free any restriction
Utaina te mauri a Rongo E tau ai, kia wātea (wātea)	Insert the energy of Rongo To restore peace and place, to free any restriction
Tūturu o whiti whakamaua kia tīna Haumi e! Hui e! Tāiki e!	Bind together, tight and unbreakable United ready to progress Unite as one Come together As one

Tūmatauenga is the deity of war and people, Whiro is a personified form of sickness, disease and death, and Rongo is the god of peace (Te Ara Encyclopaedia of New Zealand).

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Oversight of Deaths in Custody in England & Wales: a description of the landscape

Kate Eves

Kate Eves OBE

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The international legal context

Oversight of deaths in custody in England and Wales should be viewed in the context of the international human rights laws that the United Kingdom government must follow. The UK is a signatory to the European Convention on Human Rights (ECHR). Article 2 of the ECHR specifically protects the right to life, stating that: *"everyone's right to life shall be protected by law."*

The Courts, Tribunals and Judiciary Service describe how Article 2 places three broad obligations upon member states:[1]

a. A **positive duty** that the state takes appropriate steps to protect life, which has two distinct components:
   i) A general duty (sometimes referred to as the *systemic duty),* and
   ii) An operational duty (sometimes referred to as the *Osman duty*[2]*).*
b. A **negative duty** that the state refrain from taking life which also has two distinct components:
   i) A general duty (the same *systemic* duty as above) and
   ii) An operational duty to refrain from taking life by force, unless that force is lawfully justified.
c. A **procedural (investigative) duty** to investigate potential breaches of the positive or negative duty.

In England & Wales the government fulfils its investigative duty primarily through a coronial inquest. However, other entities can also play an important role and often contribute directly to the inquest.

The United Kingdom is also a signatory to the United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).[3] While OPCAT is not specifically intended to prevent deaths in custody, its focus on preventing harm means that it is closely aligned to the issue. Some of the oversight entities in the United Kingdom have remits to both prevent torture and other cruel, inhuman and degrading treatment **and** to identify issues that may increase the risk of preventable deaths in custody. These organisations include His Majesty's Inspectorate of Prisons[4] and each Independent Monitoring Board.[5]

What entities in England and Wales have a remit in relation to deaths in custody?

Coroners

Coroners in England & Wales have a remit to investigate the death of a citizen where their death was violent or unnatural deaths, where the cause is unknown or where the death occurred in custody or state detention (such as in prison, police custody or a secure hospital).[6] As an Article 2 compliant investigation, the inquest should establish the full facts; expose culpable or discreditable conduct and identify those responsible; identify wrongdoing; identify and remedy dangerous practices; and learn lessons that may save lives. It must also be independent, effective and reasonably prompt and allow sufficient public scrutiny to secure accountability. The next of kin must have the opportunity to be involved as needed to protect their legitimate interests.

At the conclusion of a Coroner's inquest, a verdict is delivered. Coroners are required by law to issue a report if, during the inquest, they identify circumstances that create a risk of future deaths.

At the conclusion of a Coroner's inquest, a verdict is delivered. Coroners are required by law to issue a report if, during the inquest, they identify circumstances that create a risk of future deaths.[7] These reports are referred to as Prevention of Future Death Reports (PFDs). The coroner must issue a PFD report to an individual, organisation, or government agency where they consider that the recipient has the ability to take actions to prevent future deaths. All PFDs are publicly available and at end of June 2026, 6,341 had been published on the Courts and Tribunals Judiciary.[8] Recipients of PFD reports are required to respond to the Coroner explaining what, if any, action they will taking within 56 days. Since January 2025, a list of PFDs that have not been responded to has also been publicly available.[9]

Police

There are 43 police forces across England and Wales. Each force has responsibility for investigation of potential crimes across its territory, including those which takes place within prisons. It is therefore the role of the local force to conduct a criminal investigation into a death in prison to identify whether any criminal wrongdoing is suspected. For deaths that were 'expected,' such as those resulting from previously diagnosed terminal illness, the police investigation is likely to be limited to providing assistance to the Coroner as part of the inquest process.

Prisons & Probation Ombudsman (PPO)

Since 2004, the PPO has had responsibility for independently[10] investigating the deaths of prisoners in England and Wales; young people in Young Offender Institutions, Secure Training Centres and Secure Children's Homes in England and Wales; and individuals detained in immigration removal centres, pre-departure accommodation, and short-term holding facilities in the United Kingdom. In addition, the PPO conducts investigations into deaths of residents of approved premises (housing for those released with licence conditions following a custodial sentence) in England and Wales.

A PPO investigation begins promptly after notification of a death at a prison, meaning that it can take place simultaneously with ongoing police enquiries. In its memorandum of understanding with the National Police Chief's Council, the PPO states: 'It is the role of the police to conduct a criminal investigation into a death. It is the role of the PPO to investigate the general circumstances and events surrounding the death, including operational and managerial matters and the clinical care of the deceased, to provide explanations and insight for bereaved relatives, and to assist the Coroner's inquest.'[11]

The police are generally given 'primacy' for their investigation, and it is their role to ensure that the PPO's investigation does not prejudice any criminal investigation (or subsequent legal proceedings). In practice, this may mean that the police require that certain people are not interviewed by the PPO or that other investigative constraints are put in place.

PPO investigators contact the family of the person who has died at an early stage of the investigation, and they are given opportunities to engage with the process throughout. The PPO provides its report to the family of the deceased, the prison authorities, and the Coroner. The report focuses on the circumstances of the death, which includes any identified failings and corresponding recommendations. Following the inquest (and, where relevant, any criminal proceedings), the PPO's report is made publicly available on its website.[12] The PPO also frequently issues thematic learning reports, drawing on the lessons it has identified from its investigations into

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deaths in custody. These thematic learning reports are published on the organisation's website.[13]

Statutory inquiries

In addition to the entities outlined above, all of which are permanent structures, the Inquiries Act 2005 legislates for one-off inquiries into matters of serious public concern. Inquiries are commissioned into a range of issues, which can include a particularly troubling death in custody.[14]

Inquiries are frequently referred to as 'statutory' or 'public' – a reference to the statutory powers that are available to compel evidence and to hold hearings in public. The report of a public inquiry is also published along with the evidence that sits behind it.

In 2009, a public inquiry report was published detailing a number of failings in relation to the self-inflicted death of Mr. Bernard 'Sonny' Lodge over 10 years earlier at HMP Manchester in the north of England.[15]

Independent Advisory Panel on Deaths in Custody (IAPDC)

The IAPDC is an advisory body which is sponsored by (but independent of) government. It is comprised of a panel of experts in the field of deaths in custody who have a remit to advise the government on the prevention of deaths in all forms of state custody: prisons, police custody, immigration detention and detention under mental health legislation.[16]

While the IAPDC is not an oversight entity, it plays an important role in providing insight into emerging patterns and themes that impact on and can prevent custody deaths. Its cross-sector remit means that it also highlights areas where practice in one sector can provide lessons in another (for example, identifying how suicide prevention measures in secure hospitals can inform better practice in prisons). Recent publications by the IAPDC include an analysis of how prison overcrowding is projected to impact on deaths[17] and a report on reduction strategies for ligatures in prisons.[18]

Conclusion

The landscape of how deaths in custody are scrutinised in England & Wales is therefore complex and layered. This increases the opportunities for learning from individual deaths and identifying themes to improve practice, prevent harm and reduce deaths. For example, the last PPO annual report documented that in the year 2024 to 2025, the PPO completed 417 death investigation reports and made a total of 506 recommendations. Of those recommendations, 165 related to the adequacy of healthcare provision; 62 related to suicide and self-harm prevention measures and 37 related to deficits in emergency responses to incidents. The PPO's report notes an example of a positive response to recommendations resulting from the death of a Black man from sickle cell crisis following restraint: 'The prison and healthcare provider's responses to the recommendations we made were positive, imaginative and clearly committed to driving improvement locally. The action plan highlighted excellent collaboration with local partners, including a sickle cell charity. We used our communication channels to share this example of good practice widely with [HM Prison and Probation Service] senior leaders'.[19]

The ongoing challenge, as in other jurisdictions with complex models of scrutiny, is to ensure that key prevention messages do not get 'lost' within this landscape. It is important to retain a focus not only on the response to recommendations but whether policy and practice changes are **implemented** and **sustained**. Finally, but crucially, there needs to be recognition of how overwhelming it can be for bereaved families to navigate a multitude of processes while grieving. Appropriate, trauma informed support is vital.

Endnotes

[1] The Article 2 inquest - Courts and Tribunals Judiciary
[2] The operational positive obligation was defined by the European Court of Human Rights in Osman v United Kingdom [1998] ECHR 101. The Court held that a violation of Article 2 arises where the authorities knew or ought to have known of a real and immediate risk to the life of an identified individual and failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk. This has become known as the Osman duty and is applied by domestic courts and coroners in a wide range of contexts. The Osman Duty and Positive Obligations - Knowledge Hub | Inquests.uk
[3]OPCAT was adopted by the United Nations General Assembly in 2002.
[4] HM Prisons Inspectorate (HMIP) is an independent oversight agency that carries out inspections of prisons across England & Wales. HMIP report on conditions and treatment of prisons.
[5] Independent Monitoring Boards (IMBs) are comprised of volunteers from the local community and are present in all prisons across England & Wales. IMBs monitor conditions and report annually on their findings.
[6] Coroners and Justice Act 2009 Section 1(2).
[7] The Coroners (Investigations) Regulations 2013 Part 7, Sections 28-29.
[8] Courts and Tribunals Judiciary: Prevention of Future Death Reports
[9] Courts and Tribunals Judiciary: non-responses to Prevention of Future Death (PFD) reports
[10] Internal investigations are also carried out by His Majesty's Prison and Probation Service (HMPPS). In its consultation with the Independent Advisory Panel on Deaths in Custody, HMPPS referred to the learning objectives of its internal investigations: "HMPPS has processes for learning from a case before the production of the Prevention of Future Death report: an early learning review (ELR) is conducted to identify any immediate learning, followed by an independent investigation report by the PPO. The inquest then occurs often well over a year after the death. Therefore, HMPPS felt that issues arising from the death have often been identified and addressed some time before the inquest. The Panel was told there is also an ongoing process of system wide learning so that lessons from other cases are informing action." More than a Paper Exercise: Enhancing the Impact of the Prevention of Future Death Reports, Independent Advisory Panel on Deaths in Custody, 2023 (P. 25)
[11] Memorandum of Understanding PPO & NPCC 2015
[12] Prisons & Probation Ombudsman: Death investigation reports
[13] Prisons and Probation Ombudsman: Learning and research documents
[14] In January 2026 there were 26 public inquiries underway into a broad range of issues included healthcare failings, the UK response to the COVID pandemic, and policing. Public inquiries | Institute for Government
[15] Report of the Inquiry into the circumstances of the Death of Bernard (Sonny) Lodge at Manchester Prison on 28 August 1998 HC 127
[16] Mental Health Act 1983 (MHA) (under s.2, s.3 or pursuant to the provisions in Part III)
[17] Prison overcrowding and deaths in England and Wales: findings from a predictive analysis and modelling study, Independent Advisory Panel on Deaths in Custody, 2023 (P. 25)
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[18] Ligature deaths in prisons in England and Wales: trends and reduction strategies, Independent Advisory Panel on Deaths in Custody, 2023 (P. 25)
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[19] PPO Annual Report 2024 to 2025 (P.25-26)

Tracking Deaths Behind Bars: How Technology Could Help Families Get Answers and Why This Matters

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Nearly two million people are incarcerated in the United States. While some states have reduced their prison populations, "the total confined population across all [systems] grew by 38,000 (2%)."[1] The crisis isn't just how many people are incarcerated, it's how many are dying there, and how little we know about the circumstances of their deaths. Experts estimate that around 6,000 people die in prisons and jails annually, with another 2,000 dying during encounters with police — these numbers are likely undercounts.[2] Between 2009 and 2019, jail deaths surged 35%, as the jail population shrank. [3]

A Law That Isn't Working

Congress passed the Death in Custody Reporting Act (DCRA) in 2000, requiring prisons, jails, and detention centers to report every death to the Department of Justice. When the law was renewed in 2013, its enforcement penalties were stripped away, weakening its power.[4] Today, there are no consequences for failing to report. Seventy percent of custodial deaths reported were missing information from federal records as recently as 2021. That year, nearly 1,000 in-custody deaths went unreported entirely.[5]

When deaths go uncounted, whether due to bureaucratic confusion or a deliberate effort to keep numbers low, it moves beyond a “data problem.” It deprives the public of information about this problem, impedes the identification of custodial death trends, and “hampers corrective actions to improve custodial, medical, and mental health care."[6] This means families are waiting for answers that may never come and navigating confusing legal and bureaucratic systems largely alone.[7]

In their 2023 book, Death In Custody: How America Ignores the Truth and What We Can Do About It, Mitchell and Aronson describe how the scale of these deaths has been deliberately obscured: "Those in power in this country are reluctant to accurately record deaths in custody, because it would pull back the veil of a system that disregards the fundamental rights of far too many people" (pp. 1–2).

Where Technology Comes In

This article explores biometric electronic monitoring devices, and how these devices could be used by families to keep tabs on incarcerated individuals in hopes of identifying health crises at an early stage and preventing deaths.[8]

Electronic monitoring (EM) devices have been used in the U.S. criminal justice system since the 1980s to supervise people on probation or house arrest. These devices use electronic signals to track individuals, and can range from "wrist bracelets, ankle bracelets, field monitoring devices, alcohol testing devices, and voice verification systems."[9] In 1983, EM devices were first tested on people who had violated probation orders.[10] By the late 1980s, EM had expanded to address prison overcrowding, diverting people away from prison sentences altogether or releasing them early and gradually transitioning them back into society and the workforce.[11] [12]

What if similar technology were used inside facilities to track the health and safety of incarcerated people, and to share that information with their families?

Real-Time Information for Families

Families often feel profound grief and helplessness after losing meaningful contact with loved ones once they are incarcerated.

Medical emergencies, deteriorating health, or even death can happen with little to no warning to loved ones on the outside. Biometric monitoring could change that. AI-enabled, wearable devices could continuously track things like heart rate, stress levels, and movement. By flagging warning signs, such as an irregular heartbeat, a sudden drop in movement, and elevated stress responses, the system could alert facility staff and family members in real time.[13]

Oversight of correctional facilities is reactive. Problems are identified after something goes wrong. AI-powered monitoring offers a proactive alternative, using machine learning to detect patterns in biometric and behavioral data that may signal an emerging health crisis or safety threat before it becomes fatal.[14]

AI-powered monitoring offers a proactive alternative, using machine learning to detect patterns in biometric and behavioral data that may signal an emerging health crisis or safety threat before it becomes fatal.

Real-time data makes deaths harder to hide and increases pressure on institutions to provide adequate care.

State and Federal Legislation

Virginia and California

EM laws vary by state. Virginia and California offer examples of how EM developed over time.

In Virginia, courts and local administrators have long had the legal authority to assign eligible individuals to home or electronic monitoring instead of jail time, under Va. Code § 53.1-131.2. The Virginia Department of Corrections (VADOC) has built on that foundation with formal operating procedures, including OP 435.5 and OP 920.7, that govern how GPS and EM devices are used as conditions of parole and post-release supervision, including specific GPS requirements for certain sex offenses.[15]

California created county home detention and EM programs in the late 20th century under Penal Code § 1203.016, and later expanded GPS monitoring significantly following Proposition 83, known as "Jessica's Law." Today, California's Department of Corrections and Rehabilitation (CDCR) runs continuous GPS programs governed by Penal Code §§ 3004 and 3010, with detailed rules laid out in Title 15 of the California Code of Regulations (§§ 3560–3569)[16] covering everything from device use to data handling.

California even criminalizes tampering with monitoring devices, making it one of the most detailed and prescriptive states in the country when it comes to parole GPS monitoring.[17] [18] [19]

Federal Constitutional Limits

At the national level, the U.S. Supreme Court has weighed in on how far electronic surveillance can go. In United States v. Jones, the Court ruled that long-term, continuous location tracking constitutes a search under the Fourth Amendment. In Grady v. North Carolina, it is further required that courts weigh whether such monitoring is reasonable before allowing it to continue indefinitely. These rulings set important guardrails on how extensively governments can surveil individuals without clear legal justification.[20] [21]

What EM Actually Looks Like Today

Modern EM involves three components:

1. Wearable devices consist of ankle or wrist monitors containing GPS radios, cellular radios, tamper sensors, as well as health sensors like heart rate monitors, accelerometers, alcohol sensors, and even COVID-19 detection technology.[22] [23] [24]
2. Back-end software platforms require vendor and cloud-based systems that receive continuous location data, manage geofencing and "no-go zone" alerts, and provide dashboards for supervision officers. Real-time alert centers handle violations and escalations. [25] [26]
3. Operational practices govern who qualifies for EM, what curfews and exclusion zones apply, how fees are handled, how violations are responded to, and how long data is retained. Correctional systems use specialized tools, such as GPS monitoring for sex-offender parolees, alcohol-monitoring wristbands, and voice verification systems. Operational challenges must be flagged, including device failures and delayed responses.[27] [28]

A New Direction: Monitoring Designed for Families

Instead of using EM technology for supervision and control, what if it were redirected toward care, giving families real-time information about their loved one's safety?

This idea reflects what Harvard Business School Professor Clayton Christensen[29] calls disruptive innovation – when a new technology enters a sector to meet underserved needs and over time disrupts the marketplace. Family-facing biometric EM would not require building something entirely new because the hardware and back-end systems already exist. The disruption lies in who the technology serves: shifting from institutional surveillance to family transparency, and from reactive crisis response to proactive health monitoring that could prevent in-custody deaths before they happen. New technology in carceral settings is deployed to strengthen institutional authority first, family protections arrive later, if at all. Family-facing biometric monitoring would represent a different model: one focused less on surveillance and control in correctional settings and more on family transparency and saving lives in custody. Yet, historically, family-oriented reforms have typically only occurred after litigation, sustained advocacy, or public backlash.

What Has Been Missing All Along

To date, no communication technology has given families an independent way to verify whether an incarcerated loved one is safe or alive. Prior innovations improved contact, but not visibility. Family-facing biometric EM would fill that gap by turning existing monitoring infrastructure into an accountability tool: a carefully scoped, real-time record of medical emergencies and suspected deaths, accessible to families and independent institutional oversight bodies. Used this way, location verification and vital-sign alerts would not expand surveillance; they would create targeted safeguards that support the government's duty of care.

A well-designed family-facing biometric monitoring system could deliver:

1. **Faster, independently verified death reporting.** Independent, civilian-accessible data streams could reduce the time it takes for families to be notified and create verifiable records of a person's location and vital signs at the moment of a custodial death, strengthening oversight and investigative processes.[30]
2. **Early warnings of medical emergencies.** Continuous heart rate monitoring can detect arrhythmia, dangerously elevated heart rates, or sudden cardiac inactivity before a crisis becomes fatal. Research increasingly supports the clinical accuracy of wearable sensors for heart rate monitoring, particularly when medical-grade sensors or validated algorithms are used. This capability could also improve medical response times.[31] Families of incarcerated individuals consistently report significant anxiety stemming from delayed or non-transparent information about their incarcerated loved one's condition. Access to life-status data could alert families and allow for early intervention with jail and prison staff, which also could reduce uncertainty and build trust with oversight systems.[32]
3. **Better data for everyone.** Real-time, independently sourced data would reduce overreliance on jail staff reports and surveillance cameras, allow for smarter deployment of medical resources, and give coroners, researchers, lawyers, and policymakers more reliable information to understand and address patterns in custodial deaths.[33]

The Risks We Cannot Ignore

Family-facing biometric monitoring has serious risks. Any honest conversation about this technology must grapple with significant challenges:

1. **Privacy and Legal Exposure.** Heart rate data and location information are among the most sensitive categories of personal data that exist. Under HIPAA, health information derived from wearable devices held by covered entities in carceral settings carries legal protection, but the boundaries of those protections are highly context dependent. As HHS guidance makes clear, legal and contractual safeguards are required to protect electronic patient health information.[34] Without strong governmental oversight, biometric data could be repurposed, sold, or accessed

by law enforcement agents, private contractors, or other third parties — violating privacy and turning a family safety tool into something far more invasive.

2. **Constitutional Concerns.** The Supreme Court's decisions in United States v. Jones and Grady v. North Carolina established constitutional limits on continuous location tracking. Expanded surveillance that includes physiological data, heartbeat, stress levels, or body movement will almost certainly invite judicial scrutiny over questions of necessity, scope, data retention, and oversight.[35] [36]
3. **Technology Failures and Operational Gaps.** Electronic monitoring systems fail. Batteries die, devices are removed, false positives trigger unnecessary alerts, and real alerts go unnoticed. Recently, juveniles died while on GPS monitoring because of system and institutional failures.[37] Without reliable staffing and response systems, biometric monitoring risks providing families with false reassurance instead of meaningful protection.
4. **Security Considerations.** Care will be needed to understand and address any security concerns relating to family members having access to information about the location and movements of an incarcerated relative.
5. **Surveillance Creep and Shifted Responsibility.** Expanding monitoring into carceral settings, even with good intentions, risks normalizing invasive oversight of a vulnerable population and disproportionately affecting people from marginalized communities. Family-facing monitoring may become a way for institutions to offload their duty of care onto families, expecting loved ones to catch medical emergencies that staff should be catching. Social science research consistently frames EM as a form of carceral control, not just supervision, which means any expansion requires careful deliberation and, critically, the genuine consent of incarcerated individuals.[38]
6. **Accuracy, Bias, and AI Limitations.** Wearable sensors don't perform equally. Heart rate monitors vary in accuracy depending on skin tone, body movement, and how the device is positioned on the body. AI models trained on datasets that don't reflect population diversity can under-detect or misclassify medical events for certain groups, producing false negatives or unnecessary false alarms. Medical reliability across diverse populations is a prerequisite.[39]

What Good Policy Would Look Like

Biometric, family-facing EM must be built on a strong foundation of legal, ethical, and technical safeguards:

1. Legal authorization: Agencies need explicit statutory authorization specifying who can be monitored, for what purposes, who can access the data, and under what procedural standards.
2. The technology should be life-safety monitoring, not broad behavioral surveillance. Pilot programs will require narrowly tailored legal authorization that clearly defines permissible monitoring, data access, oversight responsibilities, and use limits.[40]
3. Informed consent: Policies must define whether incarcerated individuals can designate specific family members to receive their biometric data, and how consent works in a setting where personal autonomy is already severely limited. The person being monitored and their designated

family members must both understand what they are agreeing to and what recourse exists if that access is denied, abused, or misused. HIPAA guidance and HHS material on health apps underscore how carefully health data sharing must be handled.[41]

4. Operational reliability: An alert that no one receives or acts on saves no one. Any effective system must include backup power sources, multiple alert channels, 24/7 staffing at triage centers with medical dispatch protocols, and guaranteed institutional response timelines. Oversight reports from DCRA and state inspectors have consistently shown that data without operational follow-through fails families and investigators.
5. Oversight, transparency, and evaluation: Every pilot program should include external evaluation, public reporting, and independent audits examining accuracy, equity, and privacy impacts. Large-scale EM programs have demonstrated that transparent, publicly available performance metrics are essential to building trust and maintaining integrity for incarcerated individuals and families.[42] [43]

Where Do We Go from Here?

EM across states show how laws, agency rules, and court decisions can enable and restrict new technology in carceral settings. Family-facing EM could improve life-safety accountability and bring long-overdue reassurance to families. That happens if it is built within a legally authorized and ethically sound framework that addresses accuracy, privacy, constitutional limits, and operational reliability. Pilot programs, targeted legislation, binding vendor contracts, independent evaluations, and clear duty-to-respond protocols are necessary prerequisites before scaling any initiative.

Family-facing EM could improve life-safety accountability and bring long-overdue reassurance to families. That happens if it is built within a legally authorized and ethically sound framework that addresses accuracy, privacy, constitutional limits, and operational reliability.

Deaths in custody are underreported. Families often receive little information after a loved one dies, sometimes learning of deaths days later. That lack of transparency erodes trust in correctional systems. EM programs in correctional settings focus on community supervision, parole, and home confinement. None have authorized family-facing biometric monitoring or family access to life-status data.

Technology now makes such monitoring feasible. Biometric-enabled wearables, designed around health and well-being rather than behavioral surveillance, could give families real-time confirmation that their loved ones are alive and, when death occurs, create a precise, independently verifiable record of its time and place.

The goal: a more humane accountability system where lives are saved, deaths are recorded, and families are informed.

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Featured Jurisdiction

New Jersey, United States

Terry Schuster

Reinventing an existing prison oversight office

Following major sexual and physical abuse scandals in 2019 in New Jersey's only women's prison, lawmakers in the state pushed for new leadership at New Jersey's Department of Corrections and gave increased funding and broad oversight powers to the state's Corrections Ombudsperson. They passed the Dignity Act, a bill that established the Ombudsperson office as an independent state agency with a mandate to investigate allegations of mistreatment and to inspect prison conditions and operations. The Ombudsperson office was initially created in the late 1970s following a riot at two men's prisons, but it had a more limited role, primarily focused on handling complaints. It also had less independence, operating within the Department of Corrections, and had no public reporting responsibilities, subpoena power, or mandate to recommend changes in law and policy. The new law revamped that office, giving Ombuds staff access to any state prison facility at any time, access to records and video footage, and the authority to have confidential communications with staff and incarcerated people. It made the office independent from the state prison system and gave it editorial independence to publish its findings and recommendations. This new law also established a narrow set of circumstances that could justify firing or removing the Ombudsperson, and gave the office powers to subpoena documents, hold public hearings, and compel testimony under oath.

With new funding and support from the state legislature and Governor, New Jersey's Office of the Corrections Ombudsperson grew from a four-person agency to a staff of 25. The new Ombudsperson changed the internal structure, creating three divisions to carry out the office's work. The largest one focused on receiving and troubleshooting complaints of mistreatment and requests for help from incarcerated people and their families. The two smaller divisions focused on monitoring systemic issues and on engaging the public.

The scale of oversight needed

The state of New Jersey has about 13,000 people incarcerated in nine state prisons and 11 contracted halfway houses. With a larger staff, the office was able to have Assistant Ombudsmen on-site at every state prison facility two to three days per week, and one Assistant Ombudsman making routine visits to each halfway house. The staff presence on-site in these facilities not only made the agency more visible to the incarcerated population but also helped the office troubleshoot concerns and build relationships with facility administrators and lower-level decision-makers over security, health care, education, social services, and classification.

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Today, the Ombudsperson office receives approximately 50 phone calls and letters each workday. Some of these complaints and requests for help can be quickly referred to facility administrators and supervisors, and others require on-site observation, face-to-face discussions with the people involved, review of records and policy, and problem-solving with prison staff.

The systemic monitoring division within the Ombudsperson office inspects prison facilities and publishes reports on facility conditions, operations, and outcomes. Some reports focus on a single facility and some focus on a theme across multiple facilities, such as access to phone calls, extreme summer heat in facilities without air conditioning, and out-of-cell time in disciplinary housing units.

Rebuilding trust with public input, reporting, and problem-solving

Given the lack of public trust after the scandals at New Jersey's women's prison, lawmakers believed it was important for the office to hold town hall meetings in communities across the state and listening tours in each of the prisons. The office needed to build the capacity to look closely at medical care and deaths in custody, which were top priorities for the families of incarcerated people. The office also took steps to create a new sense of transparency, publishing photos from inside the prisons and speaking regularly to journalists. This level of transparency was, of course, uncomfortable for leaders of the state

The Ombudsperson started holding regular meetings with the corrections leadership team and set reasonable ground rules for vetting the office's findings and attempting to resolve problems before making them public.

Department of Corrections, and at times created tension. So, it was also a top priority to build a positive and diplomatic working relationship with the prison commissioner and her leadership team. The Ombudsperson started holding regular meetings with the corrections leadership team and set reasonable ground rules for vetting the office's findings and attempting to resolve problems before making them public.

An inspection of the Garden State Youth Correctional Facility led to major renovations, better supervision of the kitchen and meal service, and replacement of 1,200 missing pillows.[1] It also sparked a more challenging, ongoing policy conversation about crowding and double-bunking in small prison cells. The office's inspection of a disciplinary housing unit at Northern State Prison led to dramatic changes impacting the population's access to showers, laundry service, trash collection, and toilet paper.[2] This inspection also launched a sustained policy discussion with the Department of Corrections about changes needed to implement the state's law prohibiting solitary confinement.

New Jersey State Prison is nearly 200 years old—it is the oldest operating prison in the United States. In addition to conducting a physical inspection of this facility, the office's systemic monitoring team combed through the state archives to review historical records about the prison. What they found was documentation of correctional leaders, policymakers, and experts for at least the last 100 years calling for the prison to be demolished and replaced because of inhumane conditions. The office described and published photos of prison cells measuring just four feet by seven feet, with no hot water, no air conditioning, no day room, and no recreation space, as well as toilets and showers that leave people exposed without adequate privacy.[3] Every person living in these cells could reach their arms out and touch both side walls. They had very little time outside of their cells and generally stayed in this prison for decades. This inspection report, published in September 2025, was the first time the Ombudsperson office had ever publicly called for a prison to be demolished and replaced.

Reports like these have helped create a public record for journalists covering prison conditions and the experiences of incarcerated people. They have armed legislators with information to question the state Department of Corrections during budgetary hearings and with policy recommendations to change state law. Since the beginning of 2026, at least 14 bills have been introduced in the New Jersey Legislature that relate to prison services, operations, and outcomes. The bills cover the size of prison cells, standards for what makes a prison housing unit habitable, release options for people in prison over the age of 60, internal processes for investigating sexual abuse, oversight of health care services in prison, public reporting of suicides in prison, and several other topics. We firmly believe that the work of the Ombudsperson office has contributed to legislators' strong interest in prison reform.

Measurable impact and culture change

In just four years, the office can also point to many concrete examples of policy changes, improvements in prison conditions, and shifts in the prison agency's priorities that were directly attributable to the Ombudsperson office's oversight activities. Concerns that surfaced from the office, for example, resulted in new restrictions on the types of rule violations that land people in disciplinary lock-up; a reduction in the number of daily strip searches women in prison are subjected to when they go to work and school; much shorter sanctions that cut a person off from contact visits with their loved ones; additional required training for nurses providing wound care in the prison hospital unit; policy changes requiring inhalers and keep-on-person medications to travel with a person when they are being transferred from one prison to another; repairs to ventilation fans needed for air circulation at one facility; and replacement of "dog kennel" cargo vans with transport vehicles that have windows, higher ceilings, and seats that face forward.

Additionally, a concern raised by the Ombudsperson office about an inadequate number of incarcerated paralegals at facilities led to a new paralegal training program. People reaching out to the Ombudsperson office in large numbers about officer behavior during search operations was one factor that led to a revised policy requiring body-worn cameras to record these searches. Ombudsperson tours and inspections led to bedbound patients receiving call bells, dramatically improved response times to sick call requests across the three largest prisons, and enforcement of the Department's existing policies on providing people with storage containers for their property.

While some resistance to oversight remains, there has been a notable cultural shift at the highest levels of the Department of Corrections away from tightly guarding information and shutting down questions toward an expectation of transparency. Today, instead of waiting for the Ombudsperson office to present the Department with complaints, facility administrators reach out directly to brief the office when there has been a death, serious injury, lockdown, power outage, staffing shortage, or other incident that might prompt concerns. The Department's leaders anticipate independent monitoring and often acknowledge its benefits even when oversight activities raise difficult or uncomfortable questions.

Meeting regularly with the Governor's office, the Ombudsperson has also armed the Governor's staff with timely information that has helped them understand major concerns, learn how various policy changes and security measures were experienced by the incarcerated population, spot problems early before they escalated or led to costly litigation, help manage the state's response to crises, secure resources when needed, and gain perspective to hold prison leaders accountable and support them with strategic planning.

The road ahead for New Jersey's prison oversight office

The Ombudsperson office in New Jersey continues to take shape in partnership with the community. In the office's most recent budget proposal, we expressed a need to hire staff members with specific expertise in legal analysis, investigations, fiscal audits, and health care services. We have hired two staff

members who are formerly incarcerated, which has increased the office's credibility in the eyes of the prison population, but has also prompted us to consider how to approach potential ethical and security concerns. We aim to create more opportunities for currently and formerly incarcerated people to help shape the work of our office.

There is also a substantial need for independent oversight of the local jail facilities in New Jersey, which (like the state prisons) have experienced violence, dangerous living conditions, and staffing shortages. The Corrections Ombudsperson office is well-positioned to take on that oversight in addition to our work overseeing state prisons, but doing so would likely require a significant effort to organize and campaign for an expansion of the office's jurisdiction and staff.

Most states in the United States have no independent prison oversight. One of the most important contributions this office can make in New Jersey is to create a model for the field of correctional oversight in this country. Building a sustainable, high-impact, and trusted Ombudsperson office here in New Jersey can help serve as proof-of-concept and a resource for lawmakers and advocates in other states who want their prisons to be safer and more humane. We can also provide a workable model for proposed or fledgling oversight bodies in other countries.

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Endnotes

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