

Grave Consequences: How the Criminalization of Disability Leads to Deaths in Jail



DRO

Disability
Rights
Oregon

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Oregon

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Executive Summary

Disability Rights Oregon (DRO) investigated ten deaths that occurred in eight Oregon jails between January 1, 2020 and October 31, 2020.¹ DRO examined the circumstances surrounding the deaths of these individuals and the failures contributing to the tragic loss of human life. Many of the deaths could have been prevented with adequate healthcare, jail oversight, and diversion to community health services in lieu of incarceration.

We have long known that jails have become the de facto mental health provider for many communities and yet are ill-equipped to provide the necessary care. The catastrophic loss of life detailed in this report demands better solutions. DRO's investigation found the following jail conditions put individuals with disabilities at risk of deadly harm:

- » **Jails use restraint practices banned in clinical settings:** In April 2020, Clatsop County Jail deputies forcibly placed a man with mental illness face down on the ground. As many as six deputies held him down in the secure entrance to the jail until he stopped moving. He stopped moving within minutes and died within a few hours. This life-threatening restraint technique is called a “prone restraint” and is banned in many schools and clinical settings for the same reasons it should be banned in the criminal justice system—it contributes directly to the inability to breath and drastically increases the risk of death.²
- » **Jails inadequately assess medical conditions:** Jail deputies and jail medical staff are unable to accurately assess medical conditions or complaints. This inability leads to death. In late January 2020, nurses and deputies at the NORCOR jail dismissed a woman's complaints of rib pain and denied her requests for hospital care. Eleven days after being booked in jail, she died there of pneumonia, a treatable disease the jail failed to timely recognize or treat. She was 26.
- » **Jails are unable to provide necessary treatment:** Jails are not designed to provide treatment and often exacerbate symptoms of mental health conditions. For example, many jails place inmates with mental illness in segregation to keep them safe. However, this isolation can have devastating impacts on mental health symptoms. Some Oregon jails are unable to prescribe psychiatric medications, while other jails have wait-times to see a prescriber through telemedicine that exceed a month. Thirty-eight percent of Oregon jails report medical positions that are budgeted but unfilled.³

¹ The deaths occurred in jails in Clatsop, Deschutes, Jackson, Klamath, Marion, and Polk counties, as well as the Springfield Municipal Jail and the NORCOR detention center in The Dalles.

² Nicole Bales, *Investigation into Warrenton Man's Death in Police Custody Finds No Excessive Force*, Astorian (Aug. 24, 2020) available at https://www.dailyastorian.com/news/local/investigation-into-warrenton-mans-death-in-police-custody-finds-no-excessive-force/article_40947a6e-e42b-11ea-8a0e-b7291152381e.html

³ Oregon Criminal Justice Commission, House Bill 3289 (2019) Report at 5.

- » **Jails often failed to take measures to prevent suicide, even when detainees presented with known risks of suicide:** Punitive jail culture rather than clinical best practices inform jail suicide precautions. Furthermore, jail staff did not perform required welfare checks to protect detainees, seriously ill detainees received wholly inadequate healthcare, or jails failed to mitigate ligature risks. Together, all of these factors contributed to the six suicide deaths identified in this report.
- » **Oregon lacks meaningful transparency and oversight of jail safety and healthcare:** Oregon does not track data related to deaths in jails and no state agency is charged with overseeing jails' provision of healthcare. Oregon law only requires jails to provide for emergency medical healthcare, but does not offer guidance into treatment for non-emergent medical and mental health conditions.⁴ This limited law was passed in 1973, decades prior to the era of mass incarceration during which Oregon jails have seen a 316 percent increase in population and an intensifying degree of physical and behavioral health needs.⁵
- » **Detainees cycle in and out of jail due to the lack of community treatment options:** In previous reports, DRO has recommended changes to stop the revolving door of people with mental health conditions being arrested for low-level, public nuisance offenses, cycling through the criminal justice system, then being released without connection to community services.⁶ When released without needed community services, individuals are left to repeat similar mental health-related conduct and re-arrest. Six of the ten individuals who died in Oregon jails in 2020 had been incarcerated many times for predominantly low-level offenses.

A Blueprint for Improving Health & Safety of People Held in Jails

DRO's investigation found both common failures and common solutions endorsed by a wide array of stakeholders. The following blueprint provides clear next steps to reduce the criminalization of people with disabilities and prevent deaths in jails.

⁴ ORS 169.076

⁵ Vera, *Incarceration Trends in Oregon*, available at <https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-oregon.pdf>

⁶ Disability Rights Oregon, *A Merry Go Round That Never Stops: Mental Illness in the Multnomah County Detention Center* at 34 (2017) available at https://static1.squarespace.com/static/5d645da3cf8e4c000158e55a/t/5f050ad4e14f582e6f4f87aa/1594165986280/A_Merry_Go_Round_That_Never_Stops_Mental_Illness_in_the_Multnomah_County_Detention_Center.pdf; Disability Rights Oregon, *The "Unwanted": Looking for Help, Landing in Jail* (Spring 2019), available at <https://static1.squarespace.com/static/5d645da3cf8e4c000158e55a/t/5f0e37c36a6e4301c92d85d9/1594767330385/Report-The-Unwanted-Looking-for-Help-Landing-in-Jail-2019-June18+%281%29.pdf>.

Recommendation: Produce Adequate Healthcare Standards and Effective Suicide Protocols for Oregon Jails

- » Revise Oregon law to produce enforceable minimum jail healthcare standards including: adequate healthcare staffing, access to medications, timely hospital transfer and continuity of care for individuals with acute care needs, and improved screening.
- » Revise protocols used by Oregon jails to replace punitive suicide watch provisions with effective suicide protocols that keep detainees in mental health crises safe.
- » Revise Oregon law to ban the use of dangerous restraint techniques that have contributed to the deaths of detainees, including prone restraint.

Recommendation: Strengthen Jail Oversight

- » Establish an independent jail inspection process to provide adequate oversight of jails.
- » Establish a transparent system for tracking deaths in Oregon jails using clear, uniform data, and make that data publicly available.

Recommendation: Prevent the Criminalization and Improper Incarceration of People with Disabilities

- » Expand community support systems for individuals with disabilities who need healthcare, social support, and help with basic needs such as housing and treatment services.
- » Revise Oregon law to ensure that detainees with acute medical and mental health conditions are taken to a healthcare facility, not booked in jail, including the right of jail commanders to refuse to book individuals whose acuity of health symptoms make them at risk of harm in a jail setting.

Introduction

Mass incarceration is a disability justice issue. Since 1970, Oregon jails have seen a 316 percent increase in population and detainees have an intensifying degree of physical and behavioral health needs.⁷ In 2018, Oregon jail commanders estimated as much as 50 percent of their population would benefit from behavioral healthcare.⁸ In some communities, jails are the largest providers of mental health services.⁹

Unlike prisons, which confine people who have been convicted of more serious crimes, jails hold people who have violated probation, are serving a short sentence on a less serious conviction, or who are being held pretrial and have not been convicted of anything.¹⁰ The most common reasons for detention in Oregon jails are probation violations and low-level charges that are associated with homelessness and behavioral health needs, such as trespass, disorderly conduct, possession of controlled substances, and probation violations.¹¹

After Oregon Public Broadcasting’s (OPB) 2019 investigation of deaths in Oregon and Washington jails,¹² the Oregon legislature tasked the Criminal Justice Commission (CJC) with creating a report examining health, safety, and risk of death in Oregon jails.¹³ Notably, the CJC’s findings on jail deaths contained a warning that the jail data was “incomplete” and “not a sufficient description or explanation of deaths in Oregon’s jails.”¹⁴

Disability Rights Oregon (DRO) conducted this investigation into deaths in Oregon’s jails in response to both OPB and CJC’s findings. Over the course of the investigation, DRO found that at least ten individuals died in eight Oregon jails in 2020 for reasons unrelated to COVID-19. The deaths occurred in jails in Clatsop, Deschutes, Jackson, Klamath, Marion, and Polk counties, as well as the Springfield Municipal Jail and the NORCOR detention

⁷ Vera, *Incarceration Trends in Oregon*, available at <https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-oregon.pdf>

⁸ See also, *Police Executive Research Forum, Managing Mental Illness in Jails: Sheriffs are Finding Promising New Approaches* at 5 (September 2018) (“Among prison inmates, up to one quarter have severe mental illness only. By some other estimates, half or more of local jail inmates have some form of mental illness.”) available at <https://www.policeforum.org/assets/mentalillnessinjails.pdf>

⁹ *Id.* at 35.

¹⁰ More than sixty percent of people held in Oregon jails are pretrial detainees. Vera, *Incarceration Trends in Oregon*.

¹¹ Oregon Criminal Justice Commission, House Bill 3289 (2019) Report at 21-22 (Sept. 15, 2020), available at <https://www.oregon.gov/cjc/CJC%20Document%20Library/HB3289ReportSept2020.pdf>.

¹² Conrad Wilson, et al, *Booked and Buried*, available at <https://www.opb.org/news/article/jail-deaths-oregon-washington-data-tracking/>

¹³ House Bill 3289 (2019)

¹⁴ Oregon Criminal Justice Commission, House Bill 3289 (2019) Report at 23.

center in The Dalles.¹⁵ DRO’s investigation found that while total jail populations have dramatically declined in 2020,¹⁶ the percentage of people dying in jail or police custody has doubled.¹⁷

While this report does not tell the entire story of each person’s death, each individual case is its own tragedy and speaks to the urgent need for action. Use of force, inadequate medical and mental healthcare, insufficient screening, and failure to follow safety protocols contributed to the deaths analyzed in this report. Criminalization of mental health conditions, lack of substantive healthcare standards, and lack of jail oversight were systemic issues uncovered through this investigation.

No one should die in jail. This report advocates for agreed-upon interventions that would make Oregon jails safer. Ultimately, the recommendations call for increased jail oversight, reducing jail populations, and protecting the lives of people with disabilities in our jails.

Investigation Methodology

There is no centralized entity or source of reliable data that tracks jail deaths in Oregon. Early in its investigation, DRO used a variety of methods—including researching news coverage, reviewing requests for DRO assistance, and reports from public defenders—to identify ten individuals who died in Oregon jails between January 1 and October 31, 2020.

As the federally-designated protection and advocacy system for the state, DRO has unique authority to access confidential records from institutions that confine people with disabilities. Using this authority, DRO requested records related to these ten jail deaths from eight jails.¹⁸ The records requested included incident reports, medical and behavioral health records, cell-check logs, suicide risk assessments, and jail policies related to intake and suicide watch. When available, DRO also reviewed video footage and hospital records. DRO also discussed some specific cases with jail commanders to garner additional details not available in the records. The jail commanders and sheriffs from the facilities provided

¹⁵ Nationally, jails death rates have increased 35 percent over the past ten years. Peter Eisler et al, *Dying Inside: The Hidden Crisis in America’s Jails Part One*, Reuters (Oct. 16, 2020) available at <https://www.reuters.com/investigates/special-report/usa-jails-deaths/>.

¹⁶ The COVID-19 pandemic has prompted jails to significantly reduce their populations. In the Spring of 2020, Disability Rights Oregon found counties have reduced jail populations by roughly half, with reductions as large as seventy-five percent in some jails. *Oregon Jails during COVID-19: A Look Inside 29 County Jails* available at <https://static1.squarespace.com/static/5d645da3cf8e4c000158e55a/t/5f0ce118b798024382bf8697/1594679577329/DRO-Report-Oregon+Jails+during+COVID-19-A+Look+Inside+29+County+Jails+%28Updated+05-01-2020%29.pdf>

¹⁷ Oregon jails reported nine deaths in 2018, seven deaths in 2019, and ten deaths between January and October of 2020. It is unknown if additional deaths have occurred in November and December of 2020.

¹⁸ Record requests were made under DRO’s authority as the Protection and Advocacy System. See the Developmental Disabilities Assistance and Bill of Rights (“DD”) Act, 42 U.S.C. § 15041, et seq., the Protection and Advocacy for Individuals with Mental Illnesses (“PAIMI”) Act, 42 U.S.C. § 10801, et seq., the Protection and Advocacy for Individual Rights (“PAIR”) Act, 29 U.S.C. § 794e, and the regulations promulgated thereto, and ORS 192.517.

extensive records in a forthcoming and timely manner. DRO reviewed the records and tracked information related to causes of death, jail compliance with safety protocols, physical and mental health treatment provided in the jail, and past bookings. DRO's investigation focused on identifying issues in individual cases and patterns between cases.

DRO's federal mandates also require that we maintain the confidentiality of our clients and their records. This report includes two detailed accounts of those who died. We were able to share these details as the family or representative of the deceased authorized the release of this information. DRO made efforts to locate family members or authorized representatives of all of the deceased. In cases where DRO was not able to locate such individuals, the confidentiality of the deceased has been protected by removing all identifying information.

Client Stories

Alex Jimenez

Alexander Jimenez was a proud U.S. army veteran and identified as Black, Native American, and Hispanic. His friends call him Alex. Alex experienced significant trauma in his life. He grew up in the foster care system, had been to prison, and had been homeless for a long period of time. He had a mental illness and struggled with addiction.

Alex ended up in the small town of Warrenton, where his veteran's fiduciary program helped him secure housing. He was feeling hopeful for the first time in a long time. He loved the local library and the Seaside Aquarium. He remained terrified of the police, to the extent that he refused to enter the DMV in order to get an ID. This fear was probably rooted in his trauma history and magnified by his mental illness. His advocate and representative through The Thom-Boy Project, Tami Herman, remembers him as a "very private person who sought nothing more than to feel safe and secure. Alex tried very hard to become comfortable with living in a home after years on the street, learning to cook and do laundry for himself; the little things others may take for granted. He enjoyed the small town feel of Warrenton, but felt oddly out of place at the same time. His skin color, his manner of self-expression in dress, and his mental illness did not invite inclusion from many of the small townspeople."

Alex was arrested for walking in the middle of the street. Local officers were acquainted with him. They had interacted with Alex approximately eight times between fall 2019 and his death in April 2020. When Alex did not respond to officers' requests to get out of the street, they arrested him and used a taser.

Due to the tasing and his mental health symptoms, officers brought Alex to the local hospital for a medical assessment of whether he was healthy enough to be safely booked in jail.

A doctor's medical assessment consisted of looking at Alex as he sat in the back of a police car yelling and moving around. The hospital did not measure Alex's vitals, examine the area where he was tased, or assess his mental health needs. Based on a cursory observation, the doctor cleared him for jail, saying "I guess you're ready to go to jail".

When officers arrived at the jail with Alex, several deputies were in the sally port¹⁹ and tried to assist with removing him from the car. DRO reviewed sally port video footage of Alex's arrival at the Clatsop County Jail, including law enforcement body cameras. In the footage, Alex struggled against police officers when they took him out of the car. They kicked his legs out from under him, forced him to the ground, and used their hands, arms, upper bodies, and knees to hold him face down on the concrete floor. At times, there were as many as six people holding him down until eventually he stopped moving.

After he lay still for several minutes, someone checked his pulse. A deputy realized he wasn't breathing, turned him over, and began chest compressions until paramedics with the fire department arrived. The paramedics took him to the hospital where they briefly revived him, but Alex Jimenez never regained consciousness and died later that day. The medical examiner's report categorized his death as "accidental due to toxic effects of methamphetamine" with fatty liver and "recent application of conductive electrical devices" noted as additional contributing factors.

Clatsop County Sheriff Matthew Phillips noted that Alex Jimenez's death "shook my staff deeply and resulted in employees seeking counseling." Sheriff Phillips has already instituted some of the reforms called for in DRO's recommendations with the Clatsop County Jail.



¹⁹ The sally port is the secured, controlled entry into the jail.

Jennifer McLaren

Jennifer McLaren was 26 years old when she died from a severe case of undiagnosed pneumonia in a jail in The Dalles. She had a history of drug possession charges and was arrested for a probation violation on January 24, 2020.

At jail booking, she began complaining of rib pain and her cellmate asked to be moved because Jennifer seemed sick and her cellmate didn't want to catch it. Eight days after her arrest, Jennifer asked to be brought to the hospital, but instead was moved to a booking cell where she could be observed more closely.

Both nurses and deputies believed she was faking her pain and difficulty moving until the day she died.

The day before her death, Jennifer became very dehydrated. This concerned medical staff, so they ordered her to drink a gallon of juice but did not attempt to have her hospitalized.

Immediately before Jennifer fell unconscious due to her illness, jail staff called emergency medical services. Emergency medical staff responded quickly, but it was too late for them to save her. Jennifer died at the jail. The medical examiner listed her cause of death as pneumonia in both lungs with blood-borne bacteria that had spread throughout her body. In most cases pneumonia is treatable, especially in a young person.

Factual Findings and Trends

The Majority of People Who Died in Oregon Jails in 2020 Had a Disability

Over half of the ten people who died in Oregon jails between January 1, 2020 and October 31, 2020 had mental illness or substance abuse disorder:

- five had documented mental health conditions;
- six committed suicide;
- eight had documented substance use disorder and six were incarcerated for charges related to their substance use when they died in custody;
- six had been in and out of jail many times for predominantly low-level offenses; and
- at least four were houseless or had a history of housing insecurity.

Suicide Was the Leading Cause of Death in Oregon Jails and Is Preventable

Jail suicide rates in Oregon are a persistent problem. Oregon Public Broadcasting reported in 2019 that the suicide rate in Oregon and Washington jails exceeded the national average,²⁰ and the rates in jails are significantly higher than those in the community. In September 2020, Oregon jails reported 212 in-facility suicide attempts over the previous year.²¹

Jails Failed to Identify and Prevent Suicide

Six of the ten individuals who died in Oregon jails in the first ten months of 2020 died by suicide. The records revealed a lack of safe jail conditions or procedures to mitigate the risk.

²⁰ Conrad Wilson, *Suicide Is the Leading Cause of Death in Oregon and Washington Jails*, OPB (April 4, 2019) available at <https://www.opb.org/news/article/suicide-oregon-washington-jails-death-investigation/>

²¹ Oregon Criminal Justice Commission, House Bill 3289 (2019) Report at 8.

None of the individuals were on suicide watch, though in some cases there were indications that the person was at risk, including a recent hospitalization for attempted suicide.

Many Jails Are Rife with Ligation Risks

All of those who committed suicide died by hanging: Each person was left unsupervised in cells with unmitigated ligation risks. Unlike hospital licensing which requires eliminating all furnishings or fixtures that a patient could use to hang themselves, there is no oversight or licensing body in Oregon that proactively requires jails to address ligation risks. Federal law, however, does require that jails remove ligation risks from their facilities.²²

Jails' Suicide Watch Protocols Increase Risk of Harm

Most jails have limited options to keep inmates who pose a suicide risk safe. Jail protocols include segregation, denying phone calls and showers, or putting inmates in suicide smocks stripping them of all other clothing and belongings. These protocols treat suicide risk punitively which deters people in jail custody from alerting jail staff of their suicidal ideation.

DRO's review of jail policies reveals that the most common suicide watch precautions are largely punitive. For example, policies dictate the removal of clothing, bedding, and personal belongings from cells or placing detainees in restrictive settings such as segregation or isolation. These restrictive measures make detainees less safe for three reasons: The extreme degree of deprivation and isolation imposed exacerbates feelings of despair; fear of a punitive response discourages detainees who feel suicidal from coming forward; and, enforcing unnecessarily harsh conditions on suicide watch creates countless reasons to impose force against individuals in psychiatric crisis.²³

Oregon law requires hourly welfare checks in correctional facilities for all inmates.²⁴ For inmates on suicide watch, welfare checks may increase to fifteen-minute intervals. In two deaths investigated by DRO, jail staff failed to conduct adequate welfare checks. Adequate welfare checks can save lives by preventing or mitigating the time inmates spend with ligatures around their necks.

²² In DOJ enforcement of the Civil Rights of Institutionalized Persons Act, unmitigated ligation risks in jails are a common violation covered. See, Special Litigation Case Summaries, US Department of Justice, <https://www.justice.gov/crt/special-litigation-section-case-summaries/download#corrections-summ>.

²³ Disability Rights Oregon, *A Merry Go Round That Never Stops: Mental Illness in the Multnomah County Detention Center* at 34 (2017) available at https://static1.squarespace.com/static/5d645da3cf8e4c000158e55a/t/5f050ad4e14f582e6f4f87aa/1594165986280/A_Merry_Go_Round_That_Never_Stops_Mental_Illness_in_the_Multnomah_County_Detention_Center.pdf.

²⁴ ORS 169.076(1)

People in Oregon Jails Were Not Afforded Adequate Medical Care during and after Their Bookings

Hospitals Cleared Still-Sick Patients, Leaving Jails with Few Safe Options to Care for These Individuals

Through this investigation, DRO found evidence that hospitals cleared individuals for jail transport without adequate examination. Under federal law,²⁵ hospitals have a statutory duty to provide stabilizing emergency care to people in medical and behavioral health crises,²⁶ which extends to individuals brought to hospitals by law enforcement prior to booking or during a crisis that began in jail custody.

Over the course of this investigation, Oregon sheriffs and jail commanders reported that local hospitals regularly clear patients for jail transport, regardless of the severity of their medical or mental health condition. In two cases reviewed for this report, hospital staff quickly released the individuals with conditions that ultimately contributed to their death.

Inappropriate and Unsafe Restraint

The risk of harm jailing people with acute mental illness is exacerbated by unsafe restraint practices to control behavior related to their disability. Alex Jimenez died after being restrained face down, also known as a “prone restraint,” by at least six deputies for several minutes.²⁷ The use of prone restraints can impair the subject’s ability to breathe, causing positional asphyxia and potential death.²⁸ Risks are elevated when combined with other factors that are prevalent in jails, such as intoxication, mental health symptoms, agitation, obesity, and respiratory distress.²⁹ Schools and clinical settings have long barred prone, or

²⁵ Emergency Medical Treatment and Labor Act (EMTALA) 42 U.S.C. § 1395dd (2020)

²⁶ For a discussion of emergency departments’ failures to treat psychiatric patients, see Alexander M. Martell, EMTALA and Psychiatric Patients, 21 DePaul J. Health Care L. 1 (2019); see also Disability Rights Oregon, *The “Unwanted”: Looking for Help, Landing in Jail* (Spring 2019), available at <https://static1.squarespace.com/static/5d645da3cf8e4c000158e55a/t/5f0e37c36a6e4301c92d85d9/1594767330385/Report-The-Unwanted-Looking-for-Help-Landing-in-Jail-2019-June18+%281%29.pdf>.

²⁷ DRO’s 2017 investigative report on conditions in the Multnomah County Detention Center – *A Merry Go Round that Never Stops* - describes multiple instances in which detainees were restrained in a prone position for prolonged periods, often pinned underneath multiple deputies. In one case described in that report, a young woman lost consciousness and suffered brain damage as a result of prone restraints.

²⁸ Lawrence Heiskell, *How to Prevent Positional Asphyxia*, Police Magazine (September 9, 2019) available at <https://www.policemag.com/524139/how-to-prevent-positional-asphyxia>

²⁹ *Id.*

face down, restraint practices due to concerns about safety.³⁰

Jails Do not Provide Quality Medical Care and Are Ill-Equipped to Monitor Serious Medical and Mental Health Conditions

DRO's investigation also found that detainees reporting symptoms were often seen as drug-seeking or otherwise faking their symptoms. Requests for medical care were dismissed. Warning signs of life-threatening medical conditions went unnoticed and unaddressed.

Jennifer McLaren was sent to jail for violating the terms of her probation. When she arrived, she complained of rib pain. Her concerns were dismissed by jail staff. Eight days later, Jennifer asked to be taken to the hospital. Jail staff denied her request for care. Jennifer died inside the jail of pneumonia a few days later. Similar circumstances—jail medical staff doubting and downplaying symptoms—led to another detainee dying in a different Oregon jail in 2020.

Jail Deputies Neglected Legally Required Hourly Welfare Checks that May Have Saved Lives

Oregon law requires hourly welfare checks in correctional facilities.³¹ In two deaths investigated by DRO, jail staff failed to conduct adequate welfare checks. As a result, the individuals laid dead for hours before being discovered by deputies. In one case, a detainee had left their bunk to commit suicide in the night and was not found until the next morning. In the second case, so much time had passed between death and discovery by deputies that rigor mortis set in, leading DRO to conclude that no welfare check had been conducted in several hours.³²

³⁰ See e.g., Equip for Equality, *National Review of Restraint Related Deaths of Children and Adults with Disabilities: The Lethal Consequences of Restraint* at 9 (2011) available at <https://www.equipforequality.org/wp-content/uploads/2014/04/National-Review-of-Restraint-Related-Deaths-of-Adults-and-Children-with-Disabilities-The-Lethal-Consequences-of-Restraint.pdf>.

³¹ ORS 169.076(1)

³² Rigor mortis <https://www.sciencedirect.com/topics/medicine-and-dentistry/rigor-mortis>

Discussion

Data Regarding Deaths in Jails Are Flawed but Point toward Rising Death Rates and a Dire Need for Oversight

Data Regarding Deaths in Jails Is Inconsistent and Opaque

As a result of Oregon Public Broadcasting (OPB)'s 2019 investigation of deaths in Oregon and Washington jails, the legislature tasked the Oregon Criminal Justice Commission (CJC) with creating a report examining health, safety, and risk of death in Oregon jails. The CJC's findings on jail deaths, however, contained the caveat that the data CJC received from jails was "incomplete" and "not a sufficient description or explanation of deaths in Oregon's jails."

Because there is no statutory requirement that jails track or report in-custody deaths, neither the CJC nor DRO were able to ascertain definitive answers to basic questions about how many people are dying in jails and why. The CJC concluded that accurate tracking of deaths in jail would require "regular, jail-by-jail, qualitative investigation."

The Number of Deaths of People Held in Oregon Jails Is Increasing

Data, albeit limited, indicate rising jail death rates in Oregon and across the country. OPB's investigation found that seven people died in Oregon jails in 2019 and nine died in custody in 2018. DRO's investigation of jail deaths during the first ten months of 2020 found that at least ten people had died in eight Oregon jails.

Jails Are Shielded from Public Scrutiny and Lack Meaningful Oversight

In a study of national media reports of people killed by police, as many as half of the people of color killed by police were also people with disabilities. This risk of harm follows Black, Indigenous, and other People of Color (BIPOC) and people with disabilities when they move from police custody to jail, but the cameras do not follow from the street into the jailhouse. As soon as an officer hands control over to a jail commander, the public can no longer use camera phones to record brutality and there are no bystanders or family to intervene or bear witness.

As a result, jails are subject only to voluntary oversight through the Oregon State Sheriffs' Association (OSSA). Currently, OSSA conducts inspections through deploying jail and sheriff's staff from other counties. Inspections are currently planned well in advance, results are not publicly available or tracked by any centralized agency, and there is no mechanism to enforce compliance with the OSSA standards.

Jails Are Not Well-Equipped to Provide Adequate Medical Care

Lack of Legal Standard for Medical Care

Oregon statutes on jail requirements have not been updated since the 1970s and require nothing beyond emergency medical treatment and delegates the responsibility for producing its own standards of medical care to each individual jail. Lack of consensus or standards regarding access to healthcare in jails creates drastic disparities across the state. People in custody in many counties are left without access to basic healthcare and life-saving treatment. Similarly, OSSA standards require jails to provide adequate healthcare, but leave the term undefined, stating that “the local medical director must determine what adequate healthcare is.” The fact that there is little consensus or guidance about what “adequate” means in the jail context confounds the structural difficulties to ensuring adequate healthcare in jail.

Jails Were not Built for Healthcare Delivery

Jails lack the physical space to treat health conditions. Historically jails have been designed, built, and staffed as facilities meant for short-term stays for pretrial detainees, not de facto healthcare facilities for people in crisis. Smaller jails may lack a clinic space to provide healthcare services and most jails do not have confidential spaces available for mental health care visits. Other jails have labyrinth-like floor plans that make it time-consuming for deputies to escort inmates to and from their healthcare appointments. In recognition of the limitations of jail healthcare, OSSA published a jail standard which allows jails to request that an arresting officer bring an arrestee in mental health crisis to a hospital for evaluation prior to booking. However, some hospitals and law enforcement agencies have resisted implementing this standard.

Recruitment and Retention Challenges Impede Adequate Clinical Staffing

DRO has visited jails that have no capacity to prescribe psychiatric medications or where wait-times to see a prescriber through telemedicine can exceed a month. Thirty-eight percent of Oregon jails report medical positions that are budgeted but unfilled because the jails are unable to recruit and retain qualified medical staff. Homer Venters, an expert in correctional healthcare, points out that “correctional health has sometimes been thought of as a career of last resort, and correctional health professionals provide care in extremely difficult settings, where their decisions are often questioned by patients and security staff alike.”³³

³³ Homer Venters, *A Three-Dimensional Action Plan to Raise the Quality of Care of US Correctional Health and Promote Alternatives to Incarceration*, Am J. Pub. Health 613 (April 2016) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4816015/>

The Criminalization of Mental Health Conditions Exposes People with Disabilities to Increased Risks of Dying in Jail

The ten people who died in Oregon jails in 2020 affirm what DRO knows generally about the population of people confined in county jails: Most are facing low-level charges related to behavioral health needs, poverty, and difficult life circumstances. The Oregon Criminal Justice Commission asserts that “jails have become the default case management system for repeat, low-level offenders who are often houseless, often have substance abuse disorders, and often have mental health issues, traumatic brain injuries, or other chronic health issues.”³⁴

Prosecuting and incarcerating people on minor charges unnecessarily exposes them to harmful conditions in jails. This is especially true for people with disabilities or complex healthcare needs. Criminalizing behavioral health conditions exacerbates existing symptoms, adds additional trauma, and further disrupts progress towards housing, services, and other stabilizing benefits in the community. The failure to adequately fund effective community-based mental health systems has directly contributed to people with disabilities in need of treatment being met with jail and prison rather than recovery and care.

³⁴ Oregon Criminal Justice Commission, House Bill 3289 (2019) Report at 19, 21.

Blueprint for Improving Jail Health & Safety

While this report highlights system failures and failures in individual facilities, there are clear solutions to these problems. Perhaps most promisingly, there is already a broad-based consensus regarding the need for change, including from the people who run jails. In 2019, jail commanders from almost every jail in Oregon shared with the Criminal Justice Commission (CJC) detailed feedback on ways to improve the health and safety of detainees in Oregon jails. CJC used the jail commanders' feedback, along with input from stakeholders, to craft a blueprint for health and safety in jails.

On September 15, 2020, the CJC's Jail Advisory Committee submitted a report with nine policy recommendations based on a survey of Oregon's local correctional facilities and a collection of data from jails' records management system during early 2019:³⁵

- » Reduce community reliance on jails for management of individuals committing frequent, low level infractions. Increase resources for community services for these individuals.
- » Reform the process by which individuals with serious mental illness or who are experiencing a mental health crisis encounter local correctional facilities. Increase diversion from jail, especially for individuals experiencing a mental health crisis.
- » Ensure that qualified staff conduct each screening.
- » Ensure Oregon Health Plan (and other insurance coverage) remains intact upon booking, during jail stays, and after re-entry.
- » Adopt minimum healthcare standards for jails.
- » Provide additional resources to recruit and retain medical staff in jails, especially for small and rural jails.
- » Consider jails and prisons as separate entities in all future policy development.
- » Facilitate continuation of treatment upon booking and ensure "warm handoffs" upon re-entry.
- » Develop a standardized jail inspection process that includes objective inspectors, a randomized inspection schedule, and reports inspection findings to the state.
- » Develop a standardized method and data format for jails to submit data to the CJC.

³⁵ Oregon Criminal Justice Commission, House Bill 3289 (2020). Report available at <https://www.oregon.gov/cjc/CJC%20Document%20Library/HB3289ReportSept2020.pdf>.

Based on Disability Rights Oregon's (DRO) investigation into jail deaths, DRO supports each of the CJC's recommendations. Based on our investigation into how and why inmates die while in custody, DRO makes seven further recommendations to increase the health and safety of inmates with disabilities. Taken together, these recommendations will improve healthcare standards and suicide protocols by strengthening jail oversight and preventing improper incarceration people with disabilities.

Recommendation: Produce Adequate Healthcare Standards and Effective Suicide Protocols for Oregon Jails

- » Revise Oregon law to produce enforceable minimum jail healthcare standards including: adequate healthcare staffing, access to medications, timely hospital transfer and continuity of care for individuals with acute care needs, and improved screening.
- » Revise protocols used by Oregon jails to replace punitive suicide watch provisions with effective suicide protocols that keep detainees in mental health crises safe.
- » Revise Oregon law to ban the use of dangerous restraint techniques that have contributed to the deaths of detainees, including prone restraint.

Recommendation: Strengthen Jail Oversight

- » Establish an independent jail inspection process to provide adequate oversight of jails.
- » Establish a transparent system for tracking deaths in Oregon jails using clear, uniform data, and make that data publicly available.

Recommendation: Prevent the Criminalization and Improper Incarceration of People with Disabilities

- » Expand community support systems for individuals with disabilities who need healthcare, social support, and help with basic needs such as housing and treatment services.
- » Revise Oregon law to ensure that detainees with acute medical and mental health conditions are taken to a healthcare facility, not booked in jail, including the right of jail commanders to refuse to book individuals whose acuity of health symptoms make them at risk of harm in a jail setting.

Conclusion

State leaders, sheriffs, and jail commanders have the difficult obligation to ensure jails are healthy and safe for both jail staff and the individuals confined to their care. This obligation has only become more difficult in recent years as jail rosters continue to increase due in part to a lack of robust community health services, housing, and diversion opportunities. For now, these individuals are being warehoused in jails that are ill-equipped to recognize the humanity of the people in jail custody. Robust mental and physical healthcare standards are necessary given the high levels of need in Oregon jails. Oversight systems must be in place to guarantee that jails meet those standards. Both are central to protecting the lives of people held in Oregon's jails.

The most powerful method for preventing deaths in Oregon jails is to end the overuse or misuse of incarceration. In the absence of community-based support for people with mental health conditions, jails will continue to act as de facto treatment centers, crisis centers, and hospitals. And once ensnared in the criminal legal system, people with mental health conditions and other disabilities face significant difficulty escaping the never-ending cycle of re-incarceration.

All ten of the tragic deaths documented in this report are the result of a long-standing public health crisis worsened by steep barriers to social support.

Judges, law enforcement, advocates, and people with lived experience in the criminal legal system agree that Oregon must stop criminalizing low-level, mental health driven behaviors. We can and must do better.

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