Dying Republic:

Police Violence and the Limits of Death Investigation in America

Terence Keel
Professor of Human Biology and Society
UCLA Institute for Society & Genetics
Department of African American Studies
Founding Director, The BioCritical Studies Lab
Advisor for Structural Competency & Innovation,
UCLA David Geffen School of Medicine

TERENCEKEEL

The BioCritical Studies Lab is an interdisciplinary space committed to studying how discrimination, inequality, and resilience are embodied in vulnerable



Terence Keel Principal Investigator



Grace Sosa **Assistant Lab Director Human Biology and Society** Class of 2022



Alexander Li Senior Project Manager **Human Biology and Society** Class of 2022





Senior Project Manager **Human Biology and Society** Class of 2022



Yuging Huang Research Project Manager **Human Biologyand Society** Class of 2022



Sarah Huang Research Project Manager **Human Biology and Society** Class of 2024



Haydee Sanchez-Resendiz Research Project Manager **Human Biology and Society** Class of 2023



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Emi Wilbur Najia Saleem Research Project Manager Research Project Manager Human Biology and Society / Physiological Science Political Science Class of 2024 Class of 2024



Research Project Manager **Human Biology and Society** Class of 2024



Nicki Añel Human Biology and Society Class of 2023

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Human Biology and Society

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Human Biology and Society Class of 2022

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Human Biology and Society

Class of 2024

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Human Biology and Society

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- Social scientists and public health scholars widely acknowledge that
 police contact is a decisive source of health inequality (1, 2) and is
 an important cause of early mortality for people of color (3).
- Police in the United States kill far more people than do police in other advanced industrial democracies (4)

- 1. A. Geller, J. Fagan, T. Tyler, B. G. Link. Aggressive policing and the mental health of young urban men. Am. J. Public Health 104, 2321–2327 (2014).
- 2. A. A. Sewell, The illness associations of police violence: Differential relationships by ethnoracial composition. Sociol. Forum **32**, 975–997 (2017).
- 3. A. L. Bui, M. M. Coates, E. C. Matthay. Years of life lost due to encounters with law enforcement in the USA, 2015 2016. J. Epidemiol. Community Health 72, 715–718 (2018).
- 4. J. Lartey. By the numbers: US police kill more in days than other countries do in years. *The Guardian*, 9 June 2015. http://www.theguardian.com/us-news/2015/jun/09/the-counted-police-killings-us-vs-other-countries.

- Police violence is a leading cause of death for young men in the United States. Over the life course, about 1 in every 1,000 black men can expect to be killed by police. Risk of being killed by police peaks between the ages of 20 y and 35 y for men & women and for all racial and ethnic groups.
- Black men are about 2.5 times more likely to be killed by police over the life course than are white men. Black women are about 1.4 times more likely to be killed by police than are white women.

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Medical Anthropology Quarterly

ORIGINAL ARTICLE

Naturalizing unnatural death in Los Angeles County jails

Nicholas Shapiro¹ Terence Keel²

¹Carceral Ecologies, Institute for Society and Genetics, UCLA, Los Angeles, California, USA

²BioCritical Studies Lab, Department of African American Studies, Institute for Society and Genetics, UCLA, Los Angeles, California, USA

Correspondence

Nicholas Shapiro, Carceral Ecologies, Institute for Society and Genetics, UCLA, Los Angeles, California, USA.

Email: nickshapiro@g.ucla.edu

Terence Keel, BioCritical Studies Lab, Department of African American Studies, Institute for Society and Genetics, UCLA, Los Angeles, California, LISA

Email: tdkeel@g.ucla.edu

Funding information

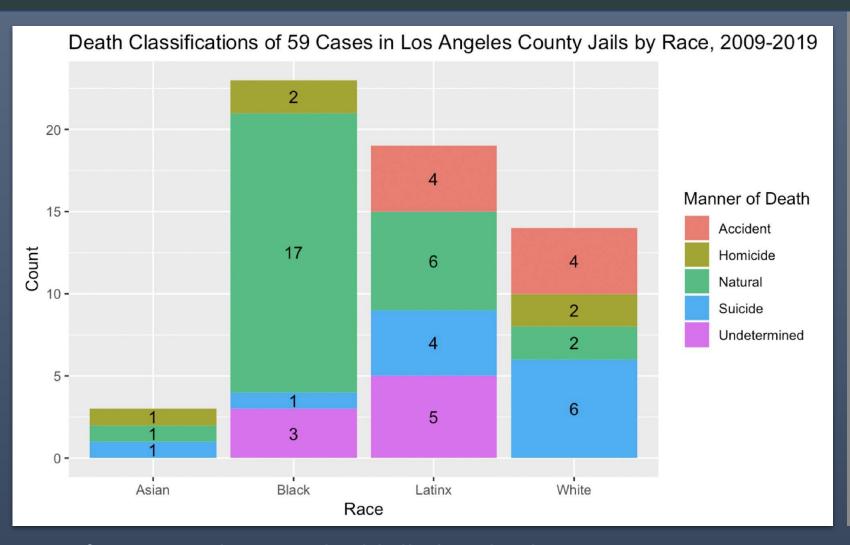
Robert Wood Johnson Foundation, Grant/Award Numbers: 108655, 79694; National Institutes of Health—National Library of Medicine, Grant/Award Number: 1G13LM013930-01; Russell Sage Foundation, Grant/Award Number: 2111-34931

Abstract

In this paper we use quantitative and qualitative methods to examine how death investigations in Los Angeles County jails disproportionately naturalize death among Black and Latino incarcerated people. Our study is based on an assessment of 58 autopsies, coroner investigator narratives, and toxicology reports produced between 2009 and 2018. We found that the Medical Examiner frequently arrived at natural or undetermined death determinations that minimized the culpability of carceral staff for loss of life that occurred within county jail. In our dataset, Black people were disproportionately classified as natural. Undetermined deaths were almost exclusively Latino. More than 75% of the cases in our study were deaths that occurred before standing trial. Our findings reveal how biomedical knowledge about incarcerated Black and Latino people is used to erase the life-diminishing effects of punishment, neglect, and maltreatment that are central to the project of mass incarceration.

Naturalizing unnatural death involves reducing lethal police encounters to problems with the the victim's biology. Death investigators who participate in this process diminish state accountability and suppress knowledge about the health effects of police violence and structural racism.

Report 1: "Natural Causes?" 59 Autopsies Prove Otherwise

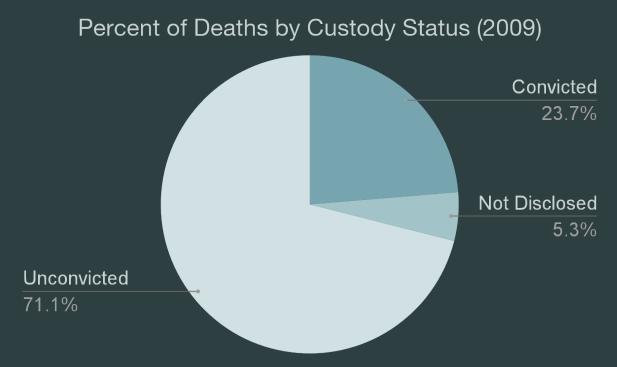


- In a sample of 59 cases, 26 deaths (44%) were ruled natural
 - ► 65% of these natural deaths were Black individuals
- More than 78% of the people in the total sample died before standing trial

Of 260 total recorded jail deaths between 2009-2019, only 59 (23%) were publicly accessible; the other 201 (77%) were on security hold.

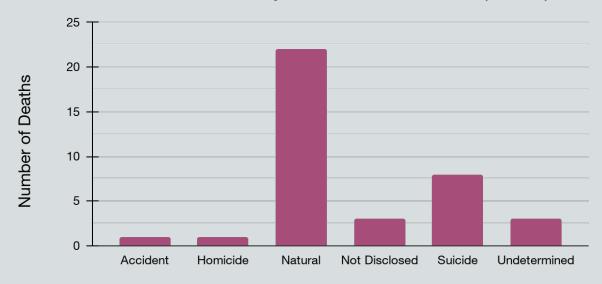
Report 2: Los Angeles County Jail Deaths 2009

2009 was the most lethal year in LA County Jails before the COVID-19 pandemic (38 total deaths)



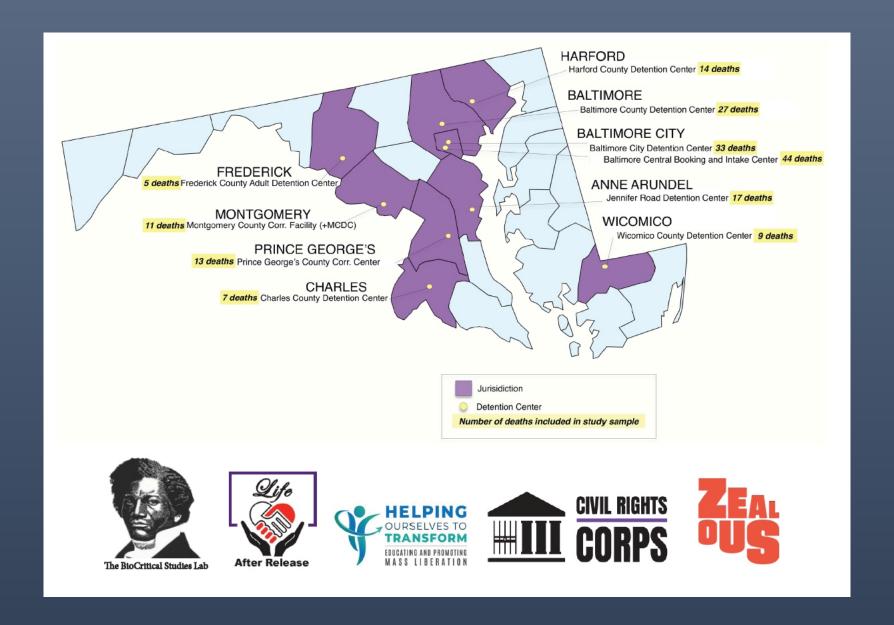
- ❖ 71% of the death cases from 2009 occurred pre-trial
 - > 70% of these pre-trial deaths were Black or Hispanic people

Number of Deaths by Manner of Death (2009)

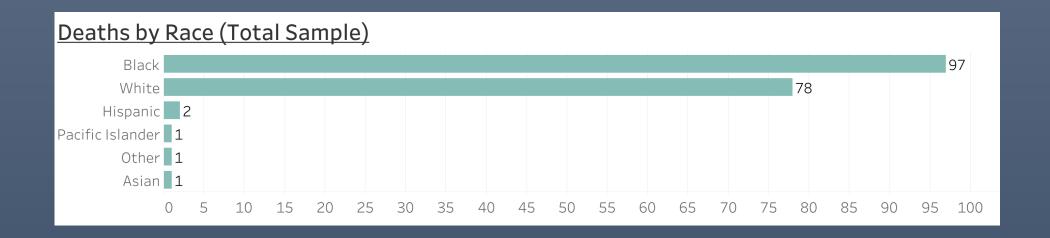


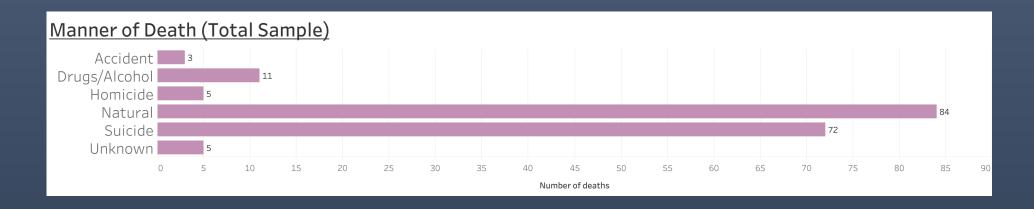
- 58% of jail deaths in 2009 were deemed natural by the LAMEC
 - > Average age at death (natural): 49 years
 - ➤ Black and Hispanic people constituted 73% of the natural deaths

180 Deaths Across 10 MD Jails & Detention Centers 2009-2018

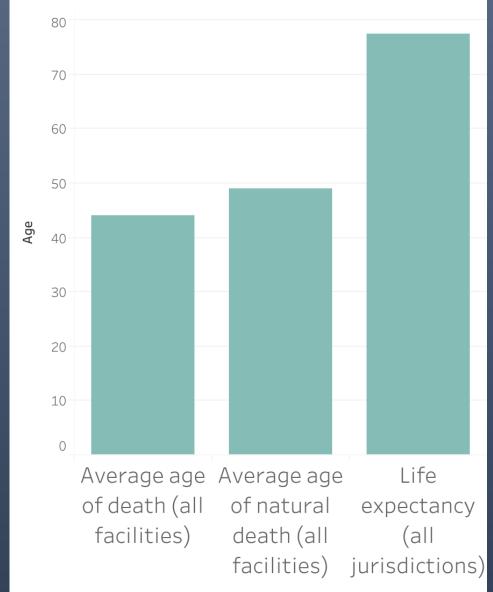


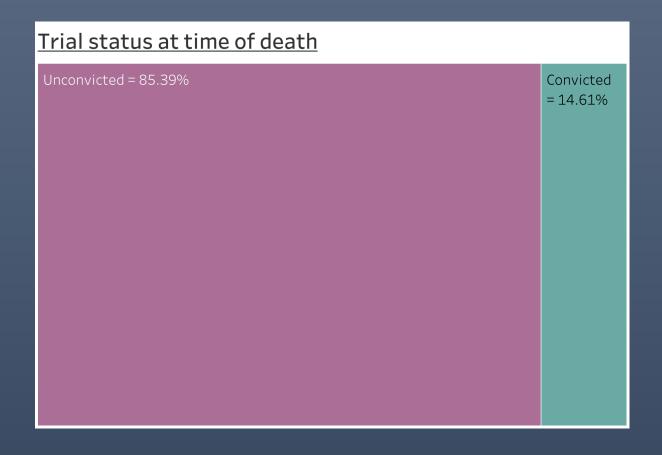
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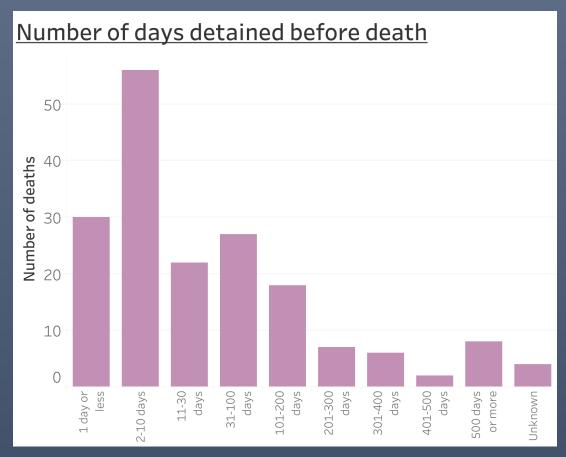


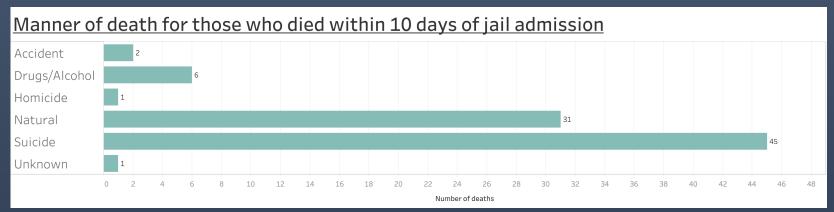


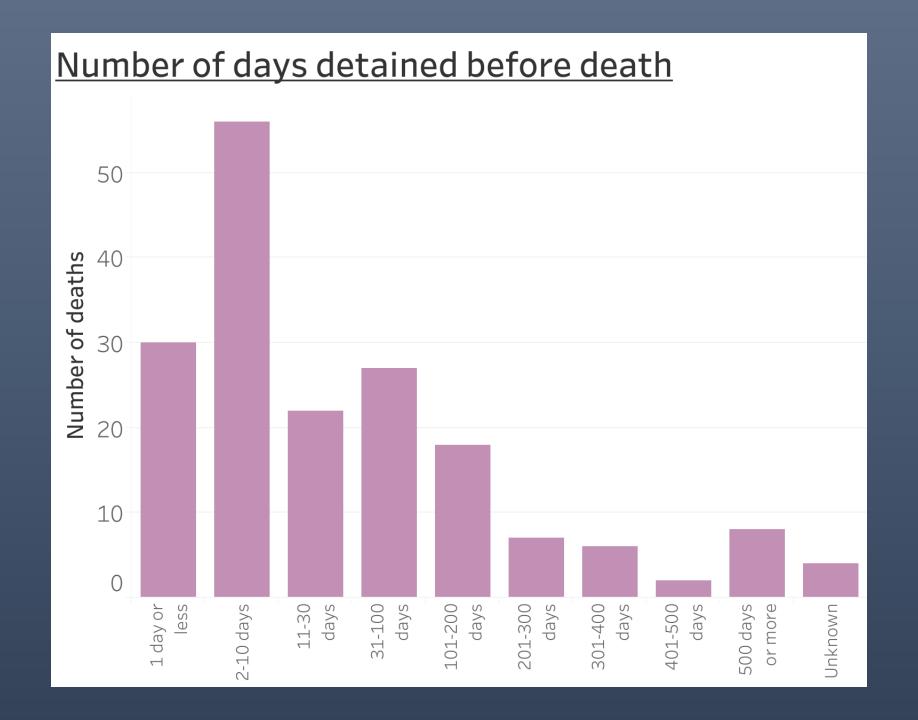
Average age of death (all facilities) and average life expectancy











SENATE BILL 36

E5 4lr0924 (PRE-FILED)

By: Senator Benson

Requested: October 11, 2023

Introduced and read first time: January 10, 2024

Assigned to: Judicial Proceedings

A BILL ENTITLED

1 AN ACT concerning

Maryland Deaths in Custody Oversight Board

FOR the purpose of establishing the Maryland Deaths in Custody Oversight Board within the Governor's Office of Crime Prevention, Youth, and Victim Services to analyze and make findings and recommendations related to deaths of incarcerated individuals; requiring the Department of Public Safety and Correctional Services to provide specific information to the Board; and generally relating to the Maryland Deaths in Custody Oversight Board.



CALIFORNIA LEGISLATURE-2021-22 REGULAR SESSION

ASSEMBLY BILL

No. 2761

Introduced by Assembly Member McCarty

February 18, 2022

An act to amend Section 102875 of the Health and Safety Code, and to add Section 10008 to the Penal Code, relating to law enforcement.

LEGISLATIVE COUNSELS DIGEST

- AB 2761, as amended, McCarty. Deaths while in law enforcement custody: reporting.
- (1) Existing law specifies the content of a certificate of death, including those items relating to medical and health data such as disease or conditions leading directly to death and antecedent causes. Existing law requires a coroner to inquire into and determine the circumstances, manner, and cause of specified deaths, including deaths in prison or while under sentence, deaths under circumstances that afford a reasonable ground to suspect that the death was caused by the criminal act of another, and all violent, sudden, or unusual deaths.

This bill would require the certificate of death to reflect when the decedent died through use of force by a peace officer, while in the custody of a peace officer, or while in the custody of state or local law enforcement, including a city or county jail or state prison. prison, and the death was precipitated by law enforcement conduct.

(2) Existing law establishes a system of state prisons under the jurisdiction of the Department of Corrections and Rehabilitation.

CA Assembly Bill 2761 (Kevin McCarty) signed into law September 2022:

- Death certificate must indicate if death occurred during use of force by peace officer, in-custody of law enforcement, or when "death was precipitated by law enforcement conduct"
- Law enforcement office with custodial status must report within 10 days of in-custody death "decedent's age, race, and gender, on its internet website within 10 days of the death. If any information regarding the death changes, the bill would also require the agency to update the posting within 30 days of the change."

26 **9-3804.**

28

$\frac{1}{2}$	(B) "BOARD" MEANS THE MARYLAND DEATHS IN CUSTODY OVERSIGHT BOARD.
3 4	(c) "Executive Director" means the Executive Director of the Governor's Office of Crime Prevention, Youth, and Victim Services.
5	9–3802.
6 7	THERE IS A MARYLAND DEATHS IN CUSTODY OVERSIGHT BOARD IN THE GOVERNOR'S OFFICE OF CRIME PREVENTION, YOUTH, AND VICTIM SERVICES.
8	9–3803.
9	(A) THE BOARD CONSISTS OF THE FOLLOWING MEMBERS:
10	(1) TWO CITIZENS WHO WERE PREVIOUSLY INCARCERATED;
11 12	(2) TWO FAMILY MEMBERS OF INDIVIDUALS INCARCERATED IN THE STATE;
13 14	(3) AT LEAST TWO REPRESENTATIVES FROM COMMUNITY ORGANIZATIONS THAT FOCUS ON JUSTICE REFORM;
15	(4) AT LEAST ONE LICENSED FORENSIC PATHOLOGIST;
16	(5) AT LEAST ONE LICENSED PSYCHIATRIST; AND
17 18	(6) ANY OTHER MEMBER DETERMINED AS NECESSARY BY THE EXECUTIVE DIRECTOR.
19 20	(B) THE EXECUTIVE DIRECTOR SHALL MAKE APPOINTMENTS TO THE BOARD AFTER SOLICITING FEEDBACK FROM THE PUBLIC.
21	(c) A member of the Board:
22 23	(1) MAY NOT RECEIVE COMPENSATION AS A MEMBER OF THE BOARD; BUT
24 25	(2) IS ENTITLED TO REIMBURSEMENT FOR EXPENSES UNDER THE STANDARD STATE TRAVEL REGULATIONS, AS PROVIDED IN THE STATE BUDGET.

	4 SENATE BILL 30
1 2 3	(2) THE MEDICATIONS PRESCRIBED TO THE DECEASED INDIVIDUAL AND WHETHER THE MEDICATIONS WERE ADMINISTERED WHILE THE DECEASED INDIVIDUAL WAS INCARCERATED;
4 5 6	(3) THE NUMBER OF TIMES THE DECEASED INDIVIDUAL RECEIVED MEDICAL CARE IN THE FACILITY'S HEALTH CARE FACILITY IMMEDIATELY BEFORE THE INCARCERATED INDIVIDUAL'S DEATH; AND
7 8 9	(4) WHETHER THE DECEASED INDIVIDUAL RECEIVED MEDICAL CARE IN AN OUTSIDE HEALTH CARE FACILITY IMMEDIATELY BEFORE THE INCARCERATED INDIVIDUAL'S DEATH.
10	9–3806.
11 12 13	(A) FOR EVERY DEATH OF AN INCARCERATED INDIVIDUAL IN THE STATE THAT IS DETERMINED TO BE A SUICIDE OR THAT OCCURRED IN CONJUNCTION WITH A MENTAL HEALTH CRISIS, THE BOARD SHALL CONDUCT AN INDEPENDENT REVIEW.
L4	(B) THE REVIEW SHALL INCLUDE:
15	(1) A REVIEW OF THE DECEASED INDIVIDUAL'S FILE; AND
L6 L7	(2) AN INTERVIEW WITH INDIVIDUALS WHO WERE FAMILIAR WITH THE DECEASED INDIVIDUAL, INCLUDING:
18	(I) FAMILY MEMBERS AND CLOSE FRIENDS;
19	(II) STAFF; AND
20	(III) OTHER INCARCERATED INDIVIDUALS.
21	9–3807.
22 23 24 25	(A) THE CORRECTIONAL FACILITY WHERE THE DECEASED INDIVIDUAL WAS INCARCERATED SHALL PROVIDE THE FOLLOWING DOCUMENTS TO THE BOARD FOR THE 6 MONTHS IMMEDIATELY PRECEDING THE INCARCERATED INDIVIDUAL'S DEATH:
26	(1) INCIDENT REPORTS AND ANY RELATED REBUTTALS;
27	(2) COMPLAINTS, WRITTEN OR SPOKEN, CONCERNING:

(I) MEDICAL ISSUES OR CONCERNS;

SENATE BILL 36

4lr0924

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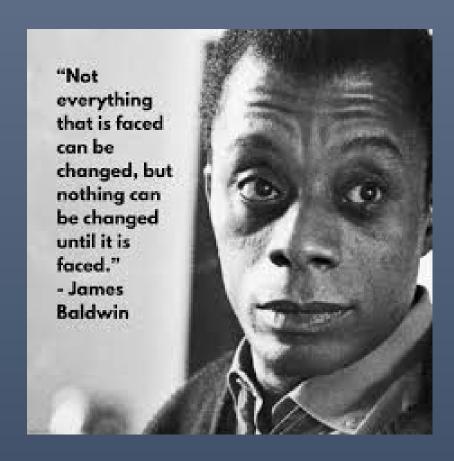
(PRE-FILED) CF HB 565 By: Senator Benson Requested: October 11, 2023 Introduced and read first time: January 10, 2024 Assigned to: Judicial Proceedings Committee Report: Favorable with amendments Senate action: Adopted Read second time: February 18, 2024 CHAPTER AN ACT concerning Maryland Deaths in Custody Oversight Board Correctional Services -Investigation of Suspected Homicide - Reporting 3 FOR the purpose of establishing the Maryland Deaths in Custody Oversight Board within the Governor's Office of Crime Prevention, Youth, and Victim Services to analyze and make findings and recommendations related to deaths of incarcerated individuals; requiring the Department of Public Safety and Correctional Services to provide specific information to the Board; and generally relating to the Maryland Deaths in Custody Oversight Board, requiring the Department of State Police to post certain information relating to certain investigations of deaths of incarcerated 10 individuals on its website; requiring the Department to report to the Governor and 11 the General Assembly on certain investigations; and generally relating to 12 investigations of deaths of incarcerated individuals. 13

	2 SENATE BILL 36
1	Article - State Government
2	SUBTITLE 38. MARYLAND DEATHS IN CUSTODY OVERSIGHT BOARD.
3	9-3801.
4 5	(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.
6 7	(B) "BOARD" MEANS THE MARYLAND DEATHS IN CUSTODY OVERSIGHT BOARD.
8 9	(C) "EXECUTIVE DIRECTOR" MEANS THE EXECUTIVE DIRECTOR OF THE GOVERNOR'S OFFICE OF CRIME PREVENTION, YOUTH, AND VICTIM SERVICES.
10	9-3802.
11 12	THERE IS A MARYLAND DEATHS IN CUSTODY OVERSIGHT BOARD IN THE GOVERNOR'S OFFICE OF CRIME PREVENTION, YOUTH, AND VICTIM SERVICES.
13	9 3803.
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20	(4) AT LEAST ONE LICENSED FORENSIC PATHOLOGIST;
21	(5) AT LEAST ONE LICENSED PSYCHIATRIST; AND
22 23	(6) ANY OTHER MEMBER DETERMINED AS NECESSARY BY THE EXECUTIVE DIRECTOR.

(B) THE EXECUTIVE DIRECTOR SHALL MAKE APPOINTMENTS TO THE

BOARD AFTER SOLICITING FEEDBACK FROM THE PUBLIC.

A MEMBER OF THE BOARD:

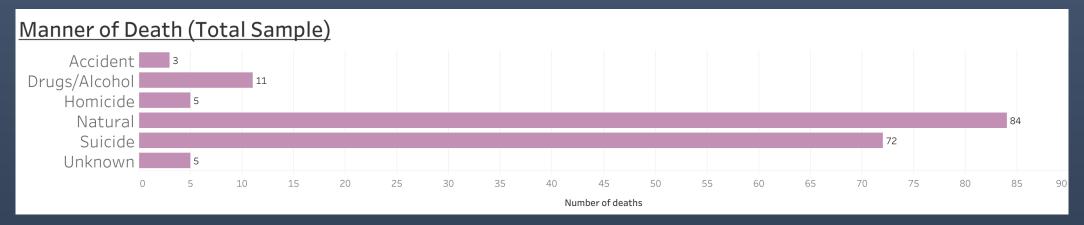


Article - Correctional Services

19 9-602.1.

18

- 20 (A) The Department of State Police shall investigate any death of an incarcerated individual suspected to be a homicide that occurs while the incarcerated individual is in the custody of the Division of Correction whether within or outside a correctional facility.
- 23 (B) ON OR BEFORE DECEMBER 31 EACH YEAR, THE DEPARTMENT OF
 24 STATE POLICE SHALL POST ON ITS WEBSITE AND SUBMIT TO THE GOVERNOR AND,
 25 IN ACCORDANCE WITH § 2–1257 OF THE STATE GOVERNMENT ARTICLE, THE
 26 GENERAL ASSEMBLY A REPORT DETAILING FOR THE PRECEDING CALENDAR YEAR:
- 27 (1) THE NUMBER OF INVESTIGATIONS COMPLETED BY THE 28 DEPARTMENT OF STATE POLICE UNDER THIS SECTION; AND
- 29 (2) THE NUMBER OF CASES REFERRED BY THE DEPARTMENT OF
 30 STATE POLICE FOR PROSECUTION FOLLOWING AN INVESTIGATION COMPLETED
 31 UNDER THIS SECTION.



Recommendations

- National guidelines for increasing decarceration and jail diversion efforts
- National standards/protocols for medical treatment following traumatic injury involving law enforcement
- National standards/protocols for treatment and surveillance of individuals suffering from mental illness or substance abuse
- National standards for using "natural" and "undetermined" death classifications following violent police encounters
- Create a national committee that investigates counties with the highest and lowest rates of in-custody death (jails and during arrest)
- National guidelines for mitigating in-custody death

Thank You

Terence Keel
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David Geffen School of Medicine
tdkeel@ucla.edu