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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA, WESTERN DIVISION

DENNIS RUTHERFORD, *et al*.,

Plaintiffs,

vs.

ROBERT LUNA, Sheriff of Los Angeles County, in his official capacity, and COUNTY OF LOS ANGELES, in their official capacities, *et al.*

Defendants.

Case No. CV 75-04111 DDP

DECLARATION OF CORENE T. KENDRICK IN SUPPORT OF PLAINTIFFS' REPLY IN SUPPORT OF MOTION FOR AN ORDER TO SHOW CAUSE RE: CONTEMPT (Doc. 375)

I, Corene T. Kendrick, hereby declare:

1. I am Deputy Director of the American Civil Liberties Union's National Prison Project (NPP), and one of the counsel of record for the Plaintiff class in this matter. I am admitted to the State Bar of California, and to practice before this Court. I make this declaration in support of Plaintiffs' Reply in Support of Motion for an Order to Show Cause re Contempt. The matters set forth herein are true and correct of my own personal knowledge, and, if called as a witness, I could and would testify competently thereto.

Front Bench Violations

2. Attached as **Exhibit A** is a table of people whom Defendants reported were held on the Front Bench for more than four hours from March 1-15, 2023. This table is submitted pursuant to Federal Rule of Evidence 1006, and was prepared in the following manner.

a. A NPP paralegal working under my supervision reviewed the Front Bench logs that Defendants provided to us for the dates March 1 through March 15, 2023. March 15 was the last day for which we were provided the logs. An example of a Front Bench log was filed with the Court on February 27, 2023 as Exhibit F to the Declaration of Peter Eliasberg (Doc. 375-3 at 47).

b. The paralegal took the following information and entered it into an Excel spreadsheet: name, booking number, date/time placed on the Front Bench, date/time removed from the Front Bench, and the reason for placement (if given) on the Front Bench. The times used are 24-hour military time, as that is the time used by officers who create these logs. To the extent there was any discrepancy (for example, no start or removal time), the paralegal made a note of that in the "Notes" column. The columns listed as "Binder#," "PDF pg#," and "Bates" refer to the

pagination and Bates numbers used by Defendants in producing the logs.

c. The paralegal used Microsoft Excel's automatic programming feature to calculate the time a person spent on the Front Bench using the start and end time information.

d. I spot-checked the accuracy of the paralegal's work by comparing a sample of her entries against the source documents, and also reviewed all logs for which she had made notes of discrepancies. For persons for whom there was no end time, but the last entry on the Log was more than four hours after the person's placement on the Front Bench (for example, a notation such as "seen by nurse"), I used for the end time that last documented time entry. Similarly, there was one person for whom the Front Bench placement time was illegible (but appeared to be 1:00 am), and the first entry documenting contact was at 10:00 am, so I used 10:00 am as his start time. As a result, those entries actually underestimate the true amount of time the person spent on the Front Bench.

e. I sorted the spreadsheet by greatest length of time on the Front Bench, and omitted the column of class members' names. I then used Excel's count feature to get a unique count of people who were on the Front Bench for more than four hours (the first column on the chart). There were 105 entries, although one person, Booking # 6558584, had two separate log sheets – one for placement on the Front Bench on March 1, 2023 from 1:00 am to 7:26 am (for 6 hours 26 minutes), and one for placement on the Front Bench on March 1, 2023 from 6:00 pm (18:00) to 11:33 pm (23:33), for another 5 hours 33 minutes. See Ex. A at Count 22 and 69.

f. Thus, there are 104 unique persons documented as being on the Front Bench for more than four hours from March 1-15, 2023.

LA County Jails' Suicide Rate

3. There were at least 12 people who died by suicide in Los Angeles County jails in 2021 according to the LA County Coroner / Medical Examiner's Office. This is the most recent year for which there is complete data, including coroner reports for all deaths in custody. *See* Robert Garrova, *A Rise In Suicides in LA Jails Underscores A Troubling Lack of Mental Health Care*, LAist/KPCC, (Mar. 31, 2023). The article is attached as **Exhibit B**, and can be found online at https://laist.com/news/criminal-justice/a-recipe-for-hopelessness-la-jails-saw-largest-spike-in-suicides-in-nearly-a-decade.

4. The U.S. Department of Justice's Bureau of Justice Statistics ("BJS") uses a methodology to calculate mortality rates at U.S. jails and prisons. This methodology is R=D/P x 100,000, where R is the mortality rate, D is the number of deaths per year, and P is the average daily population of the jail for the year, calculated by averaging the Jan. 1 and Dec. 31 daily populations. *See Hernandez v. County of Monterey*, 110 F. Supp. 3d 929, 947 (N.D. Cal. 2015); U.S. Dep't of Just., Bureau of Just. Stats., *Suicide in Local Jails and State and Federal Prisons, 2000-2019—Statistical Tables*, at 12-13 (Table 3) (Oct. 2021). The BJS report is attached as **Exhibit C**, and can be found online at https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/sljsfp0019st.pdf.

5. I used the BJS methodology to calculate LA Jails' 2021 suicide rate. The jail population on Jan. 4, 2021 was 14,778 and on Dec. 31, 2021 was 12,531, for an annual ADP for 2021 of 13,654. *See* Vera Institute for Justice, *Care First L.A.: Tracking Jail Decarceration*, at https://www.vera.org/care-first-la-tracking-jail-decarceration (Population Changes, Population Over Time). I took screenshots of the January 4, 2021 and December 31, 2021 population numbers on April 3, 2023,

and they are attached as **Exhibit D**. January 4, 2021 was the first day of the year that had publicly available daily population information. Using BJS's methodology, the average of these two numbers, or the P, is 13,654. Therefore, LA County's suicide rate is equal to 12 divided by 13,654, multiplied by 100,000, to arrive to a 2021 suicide rate of 87.9 per 100,000. This rate is more than double the rate for all California jails for 2015-19 (42 per 100,000), and almost double the national average for 2015-19 (48 per 100,000). *See* Exhibit C at Table 3.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Executed on April 3, 2022, in San Francisco, California.

/s/ Corene T. Kendrick
Corene T. Kendrick

EXHIBIT A

Count	Booking #	Hours on Front Bench	Start Date	Start Time (24 hr clock)	End Date	End Time (24 Hr Clock)	Reason	Notes	Binder#	PDF pg#	Bates
1	6551858	9:33	3/3/2023	23:40	3/4/2023	9:13	Suicidal		25	170	6830
2	6557557	8:39	3/13/2023	15:40	3/14/2023	0:19	Suicidal		23	90	6286
3	6567701	8:33	3/14/2023	0:57	3/14/2023	9:30	Suicidal		23	103	6299
4	6567700	8:26	3/14/2023	0:24	3/13/2023	8:50	Suicidal		23	101	6297
5	6557517	8:25	3/13/2023	23:57	3/14/2023	8:22	Suicidal		23	68	6264
6	6565801	8:13	3/10/2023	9:07	3/10/2023	17:20	Odd Concerning Behavior		25	51	6711
7	6563863	8:07	3/8/2023	23:24	3/9/2023	7:43	Suicidal	no end time, last entry is "urgent care visit" on 3/9/23 at 7:43	24	54	6486
8	6567702	7:55	3/13/2023	23:46	3/14/2023	7:41	Suicidal		23	66	6262
9	6558760	7:54	3/1/2023	0:01	3/1/2023	7:55	Suicidal		23	174	6370
10	6566700	7:43	3/14/2023	2:41	3/14/2023	10:24	Suicidal		23	72	6268
11	6556926	7:29	3/11/2023	0:01	3/11/2023	7:30	none selected		24	135	6567
12	6560094	7:22	3/1/2023	0:01	3/1/2023	7:23	Suicidal		23	176	6372
13	6552691	7:20	3/13/2023	15:42	3/13/2023	23:02	Suicidal		23	94	6290
14	6567657	7:15	3/14/2023	1:35	3/14/2023	8:50	Suicidal		23	1	6197
15	6559370	7:00	3/1/2023	2:00	3/1/2023	9:00	Suicidal		23	183	6379
16	6557519	6:54	3/13/2023	17:48	3/14/2023	0:42	Suicidal		23	84	6280
17	6549802	6:53	3/1/2023	0:50	3/1/2023	7:43	Odd Concerning Behavior		23	171	6367
18	6567358	6:45	3/13/2023	17:35	3/14/2023	0:20	Suicidal		23	88	6284
19	6550514	6:39	3/1/2023	3:30	3/1/2023	10:09	Suicidal		23	180	6376
20	6556831	6:38	3/13/2023	18:56	3/14/2023	1:34	Suicidal		23	79	6275
21	6564955	6:28	3/8/2023	21:27	3/9/2023	3:55	Odd Concerning Behavior		24	51	6483
22	6558584	6:26	3/1/2023	1:00	3/1/2023	7:26	Odd Concerning Behavior	appears to have been on the bench twice for more than 4 hrs this day	23	198	6394
23	6559296	6:23	2/28/2023	22:45	3/1/2023	5:08	Suicidal		25	115	6775
24	6566649	6:20	3/13/2023	19:12	3/14/2023	1:32	Self Injurious Behavior		23	81	6277
25	6567278	6:20	3/13/2023	18:20	3/14/2023	0:40	Suicidal		23	86	6282
26	6557510	6:15	3/13/2023	16:48	3/13/2023	23:03	Suicidal		23	92	6288
27	6551800	6:12	3/3/2023	18:55	3/4/2023	1:07	Suicidal		25	190	6850
28	6556424	6:07	3/7/2023	10:34	3/7/2023	16:41	Suicidal	no end time, last entry is "seen by nurse" at 16:41	23	223	6419
29	6565153	6:05	3/11/2023	10:00	3/11/2023	16:05	none selected	time placed on bench is illegible (appears to be 1:00), first "event code" is at 10:00 am for "returned to seat"	24	169	6601
30	6567207	5:54	3/12/2023	17:00	3/12/2023	22:54	Suicidal		25	75	6735
31	6560978	5:53	3/3/2023	17:16	3/3/2023	23:09	Suicidal		25	182	6842
32	6560024	5:50	2/28/2023	22:20	3/1/2023	4:10	Suicidal and Odd Concerning Behavior		25	111	6771
33	6549002	5:49	2/28/2023	23:33	3/1/2023	5:22	Odd Concerning Behavior		25	113	6773
34	6562130	5:46	3/4/2023	9:00	3/4/2023	14:46	Suicidal		25	166	6826
35	6556103	5:45	3/1/2023	16:45	3/1/2023	22:30	Odd Concerning Behavior		23	191	6387
36	6551922	5:39	3/4/2023	3:38	3/4/2023	9:17	Suicidal		25	176	6836
37	6559285	5:39	3/1/2023	2:50	3/1/2023	8:29	Suicidal		23	169	6365
38	6567970	5:38	3/14/2023	4:41	3/14/2023	10:19	Suicidal		23	70	6266
39	6556663	5:37	3/9/2023	4:20	3/9/2023	9:57	none selected		24	80	6512
40	6561752	5:36	3/4/2023	1:37	3/4/2023	7:13	Odd Concerning Behavior		25	174	6834

Count	Booking #	Hours on Front Bench	Start Date	Start Time (24 hr clock)	End Date	End Time (24 Hr Clock)	Reason	Notes	Binder#	PDF pg#	Bates
41	6567133	5:35	3/13/2023	2:40	3/13/2023	8:15	Odd Concerning Behavior		25	86	6746
42	6567962	5:34	3/14/2023	11:04	3/14/2023	16:38	none selected		23	17	6213
43	6565797	5:30	3/14/2023	4:46	3/14/2023	10:16	Odd Concerning Behavior		23	75	6271
44	6550435	5:25	3/3/2023	17:40	3/3/2023	23:05	Self Injurious Behavior		25	180	6840
45	6565646	5:19	3/13/2023	9:56	3/13/2023	15:15	Odd Concerning Behavior		25	104	6764
46	6561264	5:18	3/3/2023	19:43	3/4/2023	1:01	Suicidal		25	184	6844
47	6551849	5:17	3/3/2023	21:08	3/4/2023	2:25	Odd Concerning Behavior		25	192	6852
48	6551903	5:16	3/4/2023	1:57	3/4/2023	7:13	Suicidal		25	172	6832
49	6562123	5:13	3/4/2023	8:57	3/4/2023	14:10	Suicidal		25	212	6872
50	6556475	5:12	3/8/2023	18:08	3/8/2023	23:20	Odd Concerning Behavior		24	72	6504
51	6557178	5:06	3/13/2023	10:10	3/13/2023	15:16	Suicidal	last legible entry is 15:16 for "taken to xray"	25	107	67667
52	6560450	5:04	3/1/2023	0:01	3/1/2023	5:05	Odd Concerning Behavior		25	117	6777
53	6568045	5:01	3/15/2023	18:55	3/15/2023	23:56	Suicidal		23	13	6209
54	6567817	4:55	3/13/2023	16:45	3/13/2023	21:40	none selected		25	92	6752
55	6562432	4:53	3/3/2023	23:43	3/4/2023	4:36	Suicidal		25	194	6854
56	6568905	4:53	3/15/2023	21:14	3/16/2023	2:07	Suicidal		23	5	6201
57	6563897	4:52	3/7/2023	2:30	3/7/2023	7:22	Odd Concerning Behavior		23	124	6320
58	6553421	4:52	3/8/2023	18:34	3/8/2023	23:26	Suicidal		24	58	6490
59	6561893	4:51	3/3/2023	12:30	3/3/2023	17:21	none selected		25	162	6822
60	6565594	4:46	3/9/2023	14:29	3/9/2023	19:15	none selected		24	94	6526
61	6557030	4:46	3/15/2023	3:19	3/15/2023	8:05	Odd Concerning Behavior	no end time, last entry was he went to clinic at 8:05 am	23	41	6237
62	6561772	4:45	3/3/2023	15:45	3/3/2023	20:30	Odd Concerning Behavior		25	147	6807
63	6559006	4:45	3/15/2023	19:11	3/15/2023	23:56	none selected		23	11	6207
64	6553474	4:44	3/7/2023	0:18	3/7/2023	5:02	Suicidal		24	34	6466
65	6566639	4:41	3/13/2023	18:20	3/13/2023	23:01	Odd Concerning Behavior		23	98	6294
66	6568725	4:39	3/15/2023	13:51	3/15/2023	18:30	Suicidal		23	51	6247
67	6551805	4:38	3/3/2023	16:00	3/3/2023	20:38	Odd Concerning Behavior		25	145	6805
68	6564905	4:38	3/10/2023	19:26	3/11/2023	0:04	Suicidal		25	11	6671
69	6558584	4:33	3/1/2023	18:00	3/1/2023	22:33	Odd Concerning Behavior	appears to have been on the bench twice for more than 4 hrs this day	23	195	6391
70	6565201	4:32	3/10/2023	22:53	3/11/2023	3:25	Suicidal and Self Injurious Behavior		24	131	6563
71	6568557	4:32	3/15/2023	9:39	3/15/2023	14:11	none selected		23	62	6258
72	6566445	4:32	3/15/2023	6:40	3/15/2023	11:12	Suicidal		23	39	6235
73	6564983	4:31	3/8/2023	18:56	3/8/2023	23:27	Suicidal		24	75	6507
74	6556672	4:31	3/9/2023	19:18	3/9/2023	23:49	Suicidal		24	107	6539
75	6557080	4:31	3/11/2023	23:41	3/12/2023	4:12	Suicidal		24	190	6622
76	6564047	4:30	3/7/2023	2:58	3/7/2023	7:28	none selected		23	121	6317

Count	Booking #	Hours on Front Bench	Start Date	Start Time (24 hr clock)	End Date	End Time (24 Hr Clock)	Reason	Notes	Binder#	PDF pg#	Bates
77	6561172	4:30	3/3/2023	4:52	3/3/2023	9:22	Suicidal	no end time on log, last entry is "provided a meal" on 3/3/23 at 7:24, movement record shows he was at FB until 9:22	25	149	6809
78	6557431	4:28	3/15/2023	6:57	3/15/2023	11:25	Odd Concerning Behavior		23	37	6233
79	6556590	4:26	3/9/2023	18:47	3/9/2023	23:13	Suicidal		24	109	6541
80	6567296	4:25	3/13/2023	11:31	3/13/2023	15:56	Suicidal		25	98	6758
81	6565957	4:20	3/10/2023	17:26	3/10/2023	21:46	Suicidal	no end time, last entry is "i/m taken to urgent care" at 21:46	25	20	6680
82	6565982	4:20	3/15/2023	12:55	3/15/2023	17:15	Odd Concerning Behavior		23	64	6260
83	6563611	4:20	3/8/2023	19:11	3/8/2023	23:31	none selected		24	60	6492
84	6551270	4:19	3/3/2023	8:35	3/3/2023	12:54	none selected	no end time, movement record shows he was at FB until 12:54	25	151	6811
85	6564092	4:18	3/10/2023	3:32	3/10/2023	7:50	Suicidal		25	30	6690
86	6564109	4:15	3/7/2023	22:14	3/8/2023	2:29	none selected		23	108	6304
87	6565609	4:14	3/10/2023	2:53	3/10/2023	7:07	none selected		25	67	6727
88	6563169	4:12	3/7/2023	12:00	3/7/2023	16:12	none selected		23	214	6410
89	6560453	4:11	3/1/2023	5:30	3/1/2023	9:41	Suicidal		25	109	6769
90	6553542	4:10	3/7/2023	2:18	3/7/2023	6:28	Odd Concerning Behavior		23	141	006336-7
91	6563384	4:09	3/6/2023	2:10	3/6/2023	6:19	none selected		24	21	6453
92	6557454	4:09	3/13/2023	11:31	3/13/2023	15:40	none selected		25	100	6760
93	6556705	4:07	3/10/2023	18:33	3/10/2023	22:40	Suicidal		25	13	6673
94	6567137	4:07	3/12/2023	17:13	3/12/2023	21:20	Suicidal		25	3	6663
95	6561694	4:07	3/5/2023	10:37	3/5/2023	14:44	Odd Concerning Behavior		24	3	6435
96	6560087	4:06	3/1/2023	16:30	3/1/2023	20:36	Odd Concerning Behavior		23	189	6385
97	6557447	4:06	3/13/2023	3:05	3/13/2023	7:11	Odd Concerning Behavior		25	78	6738
98	6564262	4:05	3/10/2023	12:05	3/10/2023	16:10	Suicidal		25	59	6719
99	6565035	4:04	3/11/2023	3:38	3/11/2023	7:42	Suicidal and Self Injurious Behavior		24	138	6570
100	6567165	4:03	3/12/2023	19:05	3/12/2023	23:08	Odd Concerning Behavior		25	72	6732
101	6566382	4:03	3/11/2023	8:45	3/11/2023	12:48	Suicidal		24	154	6586
102	6556460	4:02	3/7/2023	19:05	3/7/2023	23:07	Suicidal		23	115	6311
103	6562758	4:02	3/5/2023	4:35	3/5/2023	8:37	Odd Concerning Behavior		25	198	6858
104	6557101	4:02	3/12/2023	3:43	3/12/2023	7:45	Suicidal		24	212	6644
105	6566501	4:02	3/11/2023	3:55	3/11/2023	7:57	Suicidal and Self Injurious Behavior		24	142	6574
106	6564268		3/8/2023	22:57			Suicidal	no end time, last entry is "urgent care visit" on 3/9/23, time is illegible	24	63	6495

EXHIBIT B

CRIMINAL JUSTICE

A Rise In Suicides In LA Jails Underscores A Troubling Lack Of Mental Health Care

Jail officials and county-appointed monitors alike say current care in the jails is severely deficient. Coroners' records reviewed by LAist show a jump in suicides inside L.A. County's downtown jail complex in 2021.

By Robert Garrova

Published Mar 31, 2023 6:00 AM

IN THIS ARTICLE

Conditions inside L.A. County jails have long been a problem — particularly when it comes to the care of incarcerated people with mental illness who make up a substantial percentage of the more than 14,000 people behind held on any given day.

Jail officials and county-appointed monitors alike say current care in the jails is severely deficient. Now an LAist review of coroners' records finds 2021 marked the highest number of deaths by suicide inside the downtown jail complex in eight years.

The rise in suicide deaths comes at a time when the L.A. County Jail system is plagued by a number of issues: Facilities are overcrowded, jail officials are struggling to maintain a mental health workforce, and the jails are out of compliance with requirements mandated by federal court.

mother of five whose husband died by suicide at Men's Central Jail in 2021. “It doesn’t help them ... just throwing them in jail and ignoring the fact that they’re struggling within their own mind.”

WARNING: SENSITIVE CONTENT

This story includes frequent references to suicide and self-harm.

If you or someone you know is in crisis and need immediate help, call the Suicide Prevention Lifeline by dialing 988 or go here for online chat.

The suicide of Mark Carrillo and seven others that same year at Men’s Central Jail (MCJ) and Twin Towers Correctional Facility (TTCF) marked a sharp uptick — the previous decade those facilities averaged three suicide deaths a year, according to LAist's analysis.

The 2021 cases — the most recent year with complete data — reveal serious concerns about the ability of the overcrowded jail system to care for people who are in severe distress and at high risk for suicide.

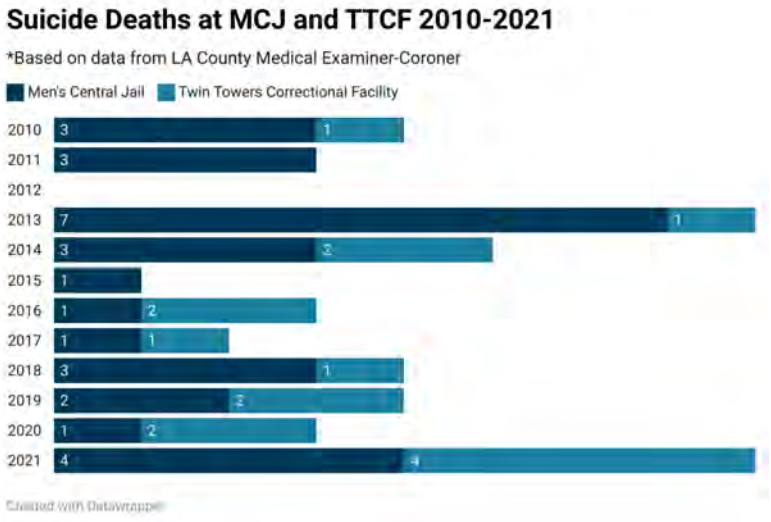
IF YOU NEED IMMEDIATE HELP

If you or someone you know is in crisis and need immediate help, call the Suicide Prevention Lifeline by dialing 988 or go here for online chat.

Find 5 Action Steps for helping someone who may be suicidal, from the National Suicide Prevention Lifeline.

Six questions to ask to help assess the severity of someone's suicide risk, from the Columbia Lighthouse Project.

- To prevent a future crisis, here's how to help someone make a safety plan.



Why some call it a 'human rights crisis'

Mark-Anthony Clayton-Johnson regularly sees conditions inside L.A.'s jails as chair of the Sybil Brand Commission, an up to 10-member body appointed by the L.A. County Board of Supervisors tasked with performing jail inspections. He said jail conditions downtown make for a "human rights crisis" that can only get worse.

2 hours ago

"It is a recipe for hopelessness," said Clayton-Johnson.

Eric Miller, a Loyola Law School professor and Sybil Brand commissioner, described some of the conditions he observed last summer as "something out of Charles Dickens," with several men naked in "filthy" cells.

> It's truly disgusting the sorts of conditions that we subject people with serious mental illness.
>
> — Eric Miller, a Loyola Law School professor and Sybil Brand commissioner

"It's truly disgusting the sorts of conditions that we subject people with serious mental illness," Miller told LAist. "It's clear that people are just getting worse when they're held under those circumstances."

In an emailed statement, the L.A. County Sheriff's Department said it is working with several stakeholders to address complex challenges "we all collectively face in our jails."

The statement goes on to say:

> "Our jails and our population have seen changes over the last few years requiring an even greater focus on our

increasing mentally ill population. We remain committed to best practices related to the safety and security of those in our custody while also providing a constitutional level of care."

Why some say it is 'impossible to provide adequate treatment'

L.A. County's Correctional Health Services (CHS), which is responsible for managing medical care for people incarcerated in county jails, continues to struggle to maintain its mental health care workforce.

Joan Hubbel, a mental health program manager for CHS, said at a February meeting of the Brand Commission that there was a roughly 44% vacancy rate for jail mental health staff. Hubbel said there are 376 budgeted mental health positions and at that time 163 were unfilled. Hubbel added that 60 people were in the process of onboarding to fill some of those empty positions, so the vacancy rate could soon drop to 27%.

More on LA jails


A Daily 'Human Rights Disaster': LA Jail Medical Staff Outraged By Jail Conditions And The Doctor In Charge

'Dickensian' Conditions At LA County Jail Amid Shortage Of Psychiatric Staff


People In Psychiatric Distress Were Shackled For Multiple Days At LA County Inmate Reception Center

The mental health staffing shortage comes at a time when the jails' mental health population is continuing to increase. Advocates point to a lack of mental health treatment beds in the community and slow movement on the county's "Care First, Jails Last" approach, which prioritizes jail diversion programs over incarceration, as part of the problem.

> The acuity and the sheer number [of people with a mental illness] have made it such that it's impossible to provide adequate

> treatment in this facility or in the jail system.
>
> — Dr. Timothy Belavich, director, Correctional Health Services

A report late last year from the L.A. County Sheriff's Department noted that people with mental health needs then stood at about 40% of the overall jail population. During the fourth quarter of 2021, the mental health population stood at 5,715 and comprised 43% of the total average inmate population of 13,319.

At a Brand Commission meeting in Sept. 2022, Dr. Timothy Belavich, the Correctional Health Services told commissioners: "The acuity and the sheer number [of people with a mental illness] have made it such that it's impossible to provide adequate treatment in this facility or in the jail system."

Later that year, Belavic told commissioners: "Not everyone wants to come work in the jail, and not everyone is ready for that type of work." He noted that the L.A. County Department of Mental Health is also struggling to fill open positions.

Shortages of clinicians make the intractable task of caring for people with serious untreated mental health conditions all the more difficult, said Dan Mistak, director of health care initiatives for justice-involved populations at Oakland-based Community Oriented Correctional Health Services.

The Los Angeles County Twin Towers Correctional facility in downtown Los Angeles.
(Andrew Cullen for LAist))

"I often call the jail the emergency department of the criminal justice system," said Mistak, whose group monitors incarcerated people's health care. "Because you get people coming in at all hours of the night [and] you don't really have a long history of understanding what's going on with them."

At the jail complex in downtown L.A., all incarcerated people undergo an initial screening with a nurse. In his report from last fall, Nicholas E. Mitchell, an independent monitor appoint by the Department of Justice to oversee jail conditions, expressed "concern" that his team "has continued to find patients with urgent or emergent conditions that were likely present at the time of the intake screening that should have been detected during a standard intake process but were not detected."

Mistak said things like depression and suicidal ideation get missed by intake screenings.

"And then on top of that you're placing them in what is far, far, far away from being a therapeutic environment," he said.

According to the Sheriff's Department, the Inmate Reception Center processes some 120,000 people a year.

The Sheriff's Department maintains two Jail Mental Evaluation Teams (JMET) made up of a deputy and mental health clinician that are tasked with assessing people locked up at the downtown complex to see if they need further mental health assessment or transfer to more appropriate housing.

What happened in the case of one suicide

In Jan. 2021, Mark Carrillo died by suicide inside a cell at Men's Central Jail (MCJ).

According to coroner records obtained by LAist, Carrillo was the second of four people to die by suicide at MCJ in 2021. His final incarceration in the L.A. County Jail system was due to a probation violation stemming from a 2015 conviction of methamphetamine possession with the intent to sell.

Carrillo's wife, Marlene Carrillo, remembers the 38-year-old father of five as a loving and caring person. "His family was his

everything, his world," she said.

Mark and Marlene Carrillo

(Courtesy of the Carrillo family)

A wrongful death lawsuit filed in July 2021 by attorneys on behalf of Marlene Carrillo and her children against L.A. County and then-Sheriff Alex Villanueva states that Mark Carrillo was diagnosed with schizophrenia around 2018. That was some two years before his last incarceration.

Marlene Carrillo said it became extremely stressful and overwhelming for her to try to help her husband with his mental illness while also taking care of their children.

"He also apologized for putting more on me by him having mental [illness]. Now, after the fact ... memories is all I have," she said. "He tried to control it, but it's uncontrollable."

Activists calling for the closure of Men's Central Jail rallied in downtown L.A. in March, 2021. (Robert Garrova/LAist)

(Robert Garrova / LAist)

Marlene Carrillo said they were unhoused at some point, and her husband was struggling to keep checking in with his probation officer.

According to the complaint, Mark Carrillo was incarcerated some seven times between 2019 and 2020 and had attempted suicide on "multiple occasions" while he was locked up previously.

Carrillo, the complaint alleges, "had a known mental health illness and known suicidal ideations, he was not given medication, nor was treated properly by a psychiatrist. He was simply left to languish."

Mark and Marlene Carrillo
(Courtesy of the Carrillo family)

Due to his diagnosed serious mental illness, prior suicide attempts and other factors, the lawsuit posits that Carrillo should have been placed in High Observation Housing (HOH) at Twin Towers during his final incarceration, but was not.

In 2021, the year Carrillo died, there was on average about 1,000 people in HOH at Twin Towers. A Jail Mental Evaluation Team can refer someone for placement in HOH, which is supposed to include more frequent safety checks.

Jail is not the answer. It doesn't help them ... just throwing them in jail and ignoring the fact that they're struggling within their own mind.

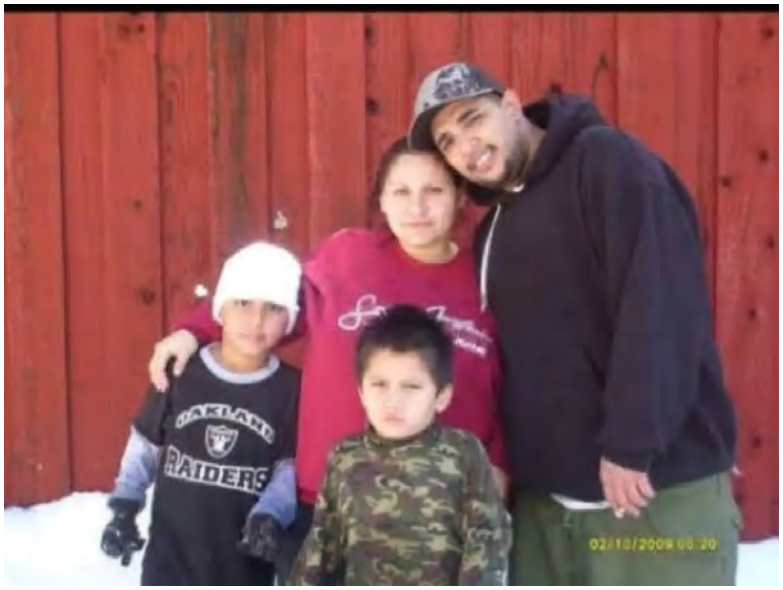
— Marlene Carillo, whose husband, Mark, died by suicide in the Men's Central Jail

The complaint says Carrillo was placed in a single-man cell at MCJ "just prior to his death." The coroner's spreadsheet marked the cause of death as "hanging."

"This man was sending out warning signals, bright red lights: 'I need help, give me help.' But nobody took it upon themselves to take that next step to do something about it and say, 'Hey, let's transfer you, let's make sure you're getting the care you need,'" said the family's attorney, Michael Carrillo (no relation).

Marlene Carrillo and her children settled their wrongful death lawsuit for $2.5 million, contingent upon the approval of the L.A. County Board of Supervisors.

Marlene Carrillo said her husband's death hasn't really sunk in for her five children yet, who used to enjoy playing baseball and going to the park with their dad. The youngest was 2 years old when Mark Carrillo died.



The Carrillo family

(Courtesy of the Carrillo family)

Carrillo said she thinks more attention needs to be paid to people who go to jail with mental health concerns.

"Jail is not the answer," she said. "It doesn't help them ... just throwing them in jail and ignoring the fact that they're struggling within their own mind."

L.A. County declined to comment on the Carrillo case, according to an email from a spokesperson for the county's Chief Executive Office. A spokesperson for the Sheriff's Department said in an email that "our heart go out to the families of Mr. Mark Carrillo ... Unfortunately, we are unable to comment on pending litigation and on circumstances related to an inmate's death."

A ballooning mental health population

In 2015, the U.S. Department of Justice entered into a settlement agreement with the county after a DOJ investigation into mental health care at county jails "found a pattern of constitutionally deficient mental health care for prisoners, including inadequate suicide prevention practices."

In 2021, the suicide rate at the jail complex downtown (TTCF and MCJ) was about one per every 1,000 people. That's more than 10 times the suicide rate for L.A. County in 2020.

Clayton-Johnson, the Sybil Brand Commission chair, said he talked with an incarcerated person on a recent jail inspection who said he didn't see a clinician for more than a month after being taken off suicide watch, when safety checks are required every 15 minutes.

Mark-Anthony Clayton-Johnson is the Sybil Brand Commission chair and executive director of the advocacy group Dignity and Power Now.

(Courtesy L.A. County)

Last year, people who work at and are familiar with conditions inside the jails system told LAist that people are not receiving care in a timely manner and staffing shortages are part of the problem.

"For people who are self-harming, the follow-up and the plan-making and all that, there's deficiencies in the ability of the jail system to meet the criteria and meet the actual settlement agreement," said Clayton-Johnson, who also serves as executive director of the advocacy group Dignity and Power Now.

Mistak of Community Oriented Correctional Health Services (COCHS) said that, ideally, if somebody is in jail and in the midst of a mental health crisis, they should be diverted to a more appropriate setting.

"If somebody is at risk of suicide, they're not going to become less at risk over time after being incarcerated, particularly if they're going to be put in a cell just by themselves," he said.

While the county has invested millions of dollars into the Office of Diversion and Reentry, which has the goal of diverting people living with mental illness from jails into community-based care, the program has struggled to meet demand partly because of a lack of funding. And the jails' mental health population has continued to balloon.

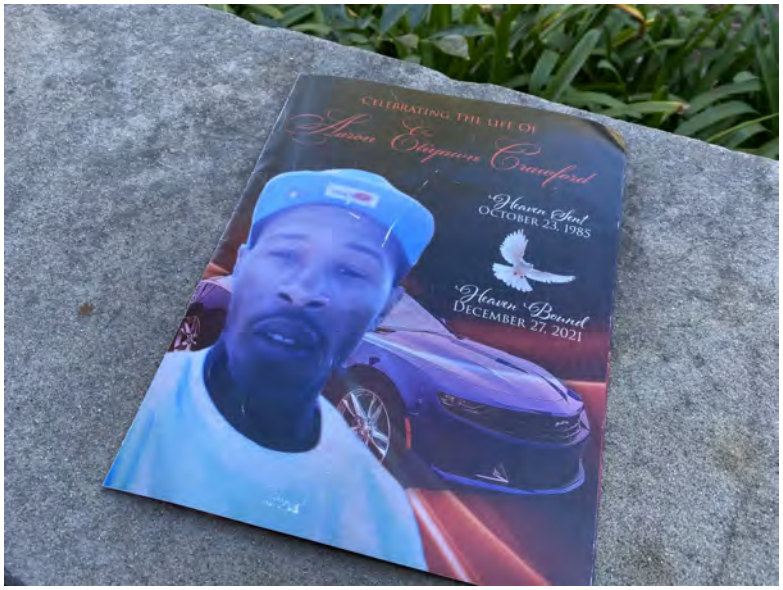
"Our jails and jail population have seen changes over the last few years requiring an even greater focus on our increasing mentally ill population," the county CEO spokesperson said in their emailed statement. "We remain committed to best practices related to the safety and security of those in our custody while also providing a constitutional level of care," the county said.

A mother says son's death 'could have been prevented'

Aaron Crawford was the last person in 2021 to die in-custody at the downtown jail complex, according to coroner data and family accounts. His mother, Debra Johnson, said she keeps her son's ashes in a necklace. She remembers Crawford as someone who could enter a room and make everybody laugh, as an excellent dancer and as someone who loved Chevrolets and family.

"He would do anything for his family," Johnson recalled.

Crawford was convicted of murder in 2021. He died by suicide at Twin Towers on Dec. 27, 2021, before he was sentenced. He was 36.



A memorial program for Aaron Crawford

(Robert Garrova / LAist)

Crawford had a difficult upbringing, Johnson said. As a child, the Department of Children and Family Services removed Crawford and his sister from their home, claiming Johnson wasn't providing adequate supervision, Johnson said.

She said Crawford bounced around between placements as a child and for a time lived at MacLaren Hall, a facility infamous for abuse allegations. Johnson said she believes Crawford suffered abuse as a child.

Although the exact timeline is unclear, Johnson said Crawford was diagnosed with schizophrenia at a young age.

"I've been yelling since the first time he was arrested — [at] probably 18 — 'he has a mental problem,'" said Crawford's sister Mikiya Davis.

Davis said Crawford had attempted suicide on more than one occasion while incarcerated and she questions to this day how her brother was able to take his own life behind bars.

The jails continue to be out of compliance with the 2015 federal settlement agreement that required the county to rectify several

serious concerns about patient care, according to a Sept. 2022 report from a court-appointed monitor who observes conditions in the jails. The U.S. Justice Department recently drew harsh criticism from four U.S. Senators for failing to take more action to fix the problems.

Monitor Nicholas Mitchell wrote in his latest report that the county "continues to struggle to appropriately intervene when inmates with mental illness engage in self-injurious behavior in jail."

Mitchell wrote that reviews from a team of mental health experts "reflect that the County remains seriously — possibly dangerously — unable to provide appropriate, tailored interventions when inmates with mental illness decompensate and engage in acts of self-harm."

For her part, Johnson said she'd like the Sheriff's Department to be held accountable for her son's death.

"It could have been prevented," Johnson said, adding that she's currently trying to find an attorney interested in filing a wrongful death lawsuit on her behalf.

Debra Johnson holds a poster of family photos that include her son, Aaron Crawford.
(Robert Garrova / LAist)

Davis said she knows her brother deserved to be in jail for taking another life. But she sees Crawford's story as the tragic outcome

of child protective services, the criminal justice system and the mental health care system all failing her brother.

"He was being locked up at an early age for things that should not have been ... jail ... These boys are being locked up for things that are not criminal, it's mental," Davis said.

L.A. County declined to comment on Crawford's death or the circumstances that led up to it, according to the CEO spokesperson's statement.

Death records under the microscope

According to coroner data, 2021 saw an increase in in-custody suicides overall. In 2021, there were 12 in-custody suicides. Besides the eight at the downtown L.A. jail complex, people also died by suicide at the Century Regional Detention Facility in Lynwood, the Palmdale Sheriff's station and a police station in Torrance.

Meanwhile, activists and researchers have questioned the accuracy of coroner records from previous years.

Researchers at UCLA's Carceral Ecologies Lab and the BioCritical Studies Lab looked at 59 autopsies between 2009 and 2019. While the autopsy reports claim that roughly half of those individuals, or 26 people, died of natural causes, "85% of these 'natural' cases involved alleged mental illness and 54% included evidence of physical violence on the body," the UCLA study says. The study, by UCLA's Terence Keel and Nicholas Shapiro, suggests that some incarcerated people are not dying from reported natural causes, but "from the actions of jail deputies and carceral staff."

Helen Jones' son John Horton died in solitary confinement at Men's Central Jail in 2009. Jones believes her son, 22, was beaten to death by deputies involved with the 3000 Boys, a deputy gang operating in the jail. The county has labeled the cause of Horton's death as "undetermined," but initially ruled that he had died by suicide.

"I knew it wasn't a suicide from day one. I know John," Jones told LAist.

In March, Jones joined other activists with JusticeLA for a rally outside the coroner's office to draw attention to what she and others believe is a misrepresentation of deaths in L.A. County jails.

Helen Jones of Dignity and Power Now spoke at a June 2022 rally at the Hall of Justice. Her son, John Horton, died inside Men's Central Jail in 2009.

(Emily Elena Dugdale / LAist)

"They don't want to say this is a murder, so they just leave it 'undetermined' to where [they're saying] 'y'all prove it now what it is,'" Jones said.

Earlier this month, the coroner's office released a statement in response to the BioCritical Lab's study.

"It has been suggested that classifying the cause of death as 'undetermined' is improper or irregular, and that this manner of death negatively impacts a criminal trial. However, classifying the cause of death as 'undetermined' is a well-accepted practice among medical examiners nationwide, and the classification does not prevent any criminal proceedings or investigations from occurring," the statement said.

It added that the coroner's office "will continue to offer unbiased and independent determinations in all of our cases."

What's next: new programs and a push to close Men's Central Jail

Dan Mistak of COHS said that for him, the interaction of mental health and the justice system "is a picture of some of our most intractable problems."

But he's hopeful about a new program that's slated to allow incarcerated individuals to take advantage of some Medi-Cal benefits 90 days before their release. Mistak said services could include case management, consultation with outside providers and medication-assisted therapy.

"It's a completely different world," he said. "It will allow for the community mental health system to actually be able to reach inside the jail and be paid for those services for the first time literally ever."

Still, the increase in suicides at the downtown jail complex comes at a time when L.A. County continues to move slowly on its promise to significantly change the jail system.

In 2021, a report by the county's Department of Diversion and Reentry and the Sheriff's Department estimated it would take up to two years to close Men's Central Jail. The report described the nearly 60-year-old facility as "unsafe, crowded and crumbling."

The proposal cites a 2020 RAND study, which found that "an estimated 61% of the jail mental health population were likely appropriate candidates for diversion."

One year after the Board of Supervisors received the report on closing Men's Central, it said in a statement that while it's committed to closing the jail "as swiftly as possible ... it is difficult to project an exact timeline."

In the statement from the CEO spokesperson, the county said it:

> "[c]annot safely depopulate and then close Men's Central Jail without first ensuring that a dynamic network of community-based care is in place and securing the full cooperation of the courts, prosecutors, and other law

enforcement agencies in diverting or releasing individuals from jail."

The county said the MCJ population must be cut in half before it can begin shutting down the facility. According to the county, several agencies, including the Department of Mental Health and the Office of Diversion and Reentry, "are in the process of building out a robust network of community care that would provide alternatives to custody that could be utilized by those with the authority to release individuals from custody."

Last year, the ACLU urged a federal court to order immediate improvements to conditions at Los Angeles' Inmate Reception Center (IRC), which is at the Twin Towers Correctional Facility. The ACLU described the conditions at the IRC as "abysmal," and alleged its attorneys who recently visited the facility saw "[p]eople with serious mental illness chained to chairs for days at a time, where they sleep sitting up ... People defecating in trash cans and urinating on the floor or in empty food containers in shared spaces," and several other disturbing observations.

"L.A. County agrees that the conditions in the Inmate Reception Center have not been acceptable in the past," the CEO spokesperson's statement said. County officials said they're doing everything in their power to comply with the court orders, including:

- "assigning additional mental health staff to the IRC Clinic"
- "converting general population beds into mental health beds"
- "designating a supervisor on each shift to ensure compliance"
- "taking additional steps to ensure that individuals awaiting mental health assessment are provided with access to beds, blankets, restrooms, showers, telephones, and medical care"

Protesters rallied on March 30, 2023 to call on L.A. County to close Men's Central Jail by March 2025.

(Robert Garrova / LAist)

Clayton-Johnson of Dignity and Power Now and the Sybil Brand Commission said that during a recent jail inspection of TTCF he observed a person who had smeared feces on the walls of a cell. He said poor hygiene conditions coupled with delays in receiving care make for a dire situation.

"It is a recipe for something bad to happen ... it is a recipe for hopelessness," Clayton-Johnson said.

He believes adequate mental health staffing within the jail system is not a panacea. Clayton-Johnson would like to see the county set up more mental health treatment beds in the community "to stop people from ending up in [jail] in the first place."

He called this a "critical moment around whether the county will be steadfast in its trajectory" to close Men's Central Jail.

"Without a concrete timeline to close Men's Central Jail, this regressive reality that we're in — which is really a human rights crisis — is just going to get worse," Clayton-Johnson said.

This story was a collaboration with the USC Annenberg Center for Health Journalism.

ASK FOR HELP

EXHIBIT C

U.S. Department of Justice
Office of Justice Programs
Bureau of Justice Statistics

October 2021, NCJ 300731

Bureau of Justice Statistics • **Statistical Tables**

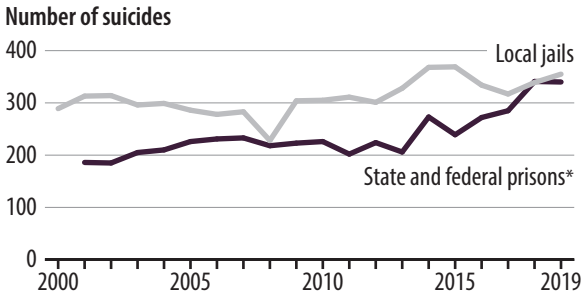
Suicide in Local Jails and State and Federal Prisons, 2000–2019 – Statistical Tables

E. Ann Carson, Ph.D., *BJS Statistician*

The total number of suicides in state, federal, and local correctional facilities increased from 499 in 2001 to 695 in 2019 (**figure 1, table 1**). From 2001 to 2019, suicides accounted for 5% to 8% of all deaths among state and federal prisoners and 24% to 35% of deaths among local jail inmates. Most jail inmates and state and federal prisoners who died by suicide were males, were non-Hispanic whites, and died by means of suffocation, including hanging and self-strangulation. More than half of all suicides in local jails occurred within the first 30 days of incarceration, while the overwhelming majority of suicides in state and federal prisons took place after the prisoners had served more than a year of their sentence.

In 2019, a total of 355 local jail inmates died by suicide. Almost 13% of jails operating above their rated or design capacity had one or more suicides, compared to approximately 9% of jails operating at or below capacity. Deaths by suicide

FIGURE 1
Number of suicides in local jails and state and federal prisons, 2000–2019



Note: Jail counts exclude and prison counts include deaths in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. See table 1 for counts.

*Includes deaths in publicly and privately operated state facilities. Includes deaths in Federal Bureau of Prisons facilities and excludes deaths in privately operated federal facilities. See *Methodology*.

Source: Bureau of Justice Statistics, Federal Law Enforcement Agency Deaths in Custody Reporting Program, 2015–2019; Mortality in Correctional Institutions, 2000–2019; and National Prisoner Statistics program, 2001–2019.

Highlights

- From 2001 to 2019, the number of suicides increased 85% in state prisons, 61% in federal prisons, and 13% in local jails.
- During 2010-19, suffocation, including hanging and self-strangulation, accounted for nearly 90% of suicide deaths in local jails.
- During 2015-19, about 12% of deaths by suicide in local jails occurred within the first 24 hours of incarceration, a decrease from almost 22% during 2000-04.
- The average suicide rate for white inmates in local jails was 93 per 100,000 during the 5-year period of 2015-19, which is 5 times the rate for black inmates (18 per 100,000) and more than 3 times the rate for Hispanic inmates (26 per 100,000).
- Almost 60% of state prisoners who died by suicide during 2001-19 were white.
- During 2001-19, state prisoners who had been sentenced for a violent offense accounted for almost 72% of suicides in state prisons.
- During 2015-19, about 75% of suicides in state prisons and 64% of suicides in federal prisons occurred after the first year of imprisonment.
- Persons serving time in federal prison for weapons offenses and sex offenses each accounted for about 20% of suicides in federal facilities during 2015-19.
- In 2019, suicides occurred in 217 state and federal prisons, 19% of all prison facilities.

in 2019 were concentrated in the largest jails. More than half of local jails housing 1,000 or more inmates on June 30, 2019 reported at least one inmate suicide.

In 2019, 340 state and federal prisoners died by suicide. Similar to local jails, suicides were more likely to occur in large state and federal prison facilities. About 45% of state and federal prisons that held 2,500 or more prisoners at midyear 2019 reported one or more suicides.

This report fulfills a House Appropriations Committee request to publish data in 2021 on suicides in jails and prisons. These statistical tables present data from the Mortality in Correctional Institutions collection, through which the Bureau of Justice Statistics (BJS) obtained data on deaths in jails from 2000 to 2019 and deaths in state prisons from 2001 to 2019. Data on deaths in federal prisons were obtained from aggregate counts reported to BJS's National Prisoner Statistics program from 2001 to 2014, and from individual-level death data collected through the Federal Law Enforcement Agency Deaths in Custody Reporting Program from 2015 to 2019.

Deaths are aggregated into 5-year periods in this report so stable suicide rates can be calculated from the suicide counts. The tables describe geographic, demographic, and criminal justice characteristics of jail inmate and prisoner suicides, as well as circumstances surrounding the deaths. Suicides that occurred in 2019 are linked to data from BJS's *2019 Census of Local Jails* and *2019 Census of State and Federal Correctional Facilities* to describe characteristics of facilities that had a suicide.

Suicides in local jails

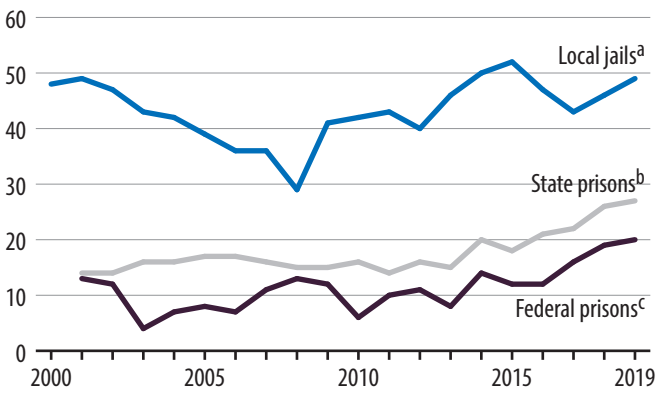
- Local jails had 355 deaths by suicide in 2019, an increase from 289 in 2000.
- During the 20-year period of 2000-19, California had a total of 615 suicides in local jails, Texas had 448, Florida had 333, and Pennsylvania had 325 **(table 2)**.
- The suicide rate among local jail inmates in 2019 (49 per 100,000) was similar to the rate in 2000 (48 per 100,000) **(figure 2)**.
- The suicide rate in local jails peaked in 2015 at 52 per 100,000 inmates.
- During 2000-19, local jails in the South had 2,608 suicides, compared to 1,494 for jails in the West, 1,350 for jails in the Midwest, and 765 for those in the Northeast **(table 3)**.

Demographic characteristics of local jail inmates who died by suicide

- During 2000-19, 90% of local jails inmates who died by suicide were male **(table 4)**.
- The number of deaths by suicide among female local jail inmates increased from 124 to 204 deaths between the periods of 2000-04 and 2015-19, rising almost 65%.
- Seventy-four percent of local jail inmates who died by suicide during 2015-19 were white, while almost 12% were Hispanic and 11% were black.
- During 2000-19, American Indians and Alaska Natives accounted for 2% (120 deaths) and Asians, Native Hawaiians, and Other Pacific Islanders accounted for about 1% (74) of suicides in local jails.
- Sixty percent of inmates who died by suicide in local jails during 2000-19 were ages 25 to 44.

FIGURE 2

Rate of suicides per 100,000 inmates in local jails and 100,000 prisoners in state and federal prisons, 2000–2019



Note: Jail rates exclude and state prison rates include deaths in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Data may have been revised from previously published statistics. See *Methodology*. See table 1 for rates.

[a]Based on the annual number of suicides and the average daily population (ADP) in local jails. In 2000, the ADP was estimated by taking the average of January 1 and December 31 inmate population counts.

[b]Based on the annual number of suicides and the December 31 custody population in state prisons. Includes deaths and populations in publicly and privately operated state facilities.

[c]Based on the annual number of suicides and the December 31 custody population in federal prisons. Includes deaths and populations in Federal Bureau of Prisons facilities and excludes deaths and populations in privately operated federal facilities. See *Methodology*.

Source: Bureau of Justice Statistics, Federal Law Enforcement Agency Deaths in Custody Reporting Program, 2015–2019; Mortality in Correctional Institutions, 2000–2019; and National Prisoner Statistics program, 2001–2019.

- Among jail inmates who died by suicide, the percentage who were age 55 or older increased from 3% during 2000-04 to 9% during 2015-19.
- The average suicide rate during 2000-19 for white inmates was 86 per 100,000, more than 5 times the rate for black inmates (16 per 100,000) and almost 3.5 times the rate for Hispanic inmates (25 per 100,000) **(table 5)**.
- The average suicide rate for local jail inmates age 24 or younger was highest during 2000-04 (36 per 100,000) and lowest during 2015-19 (20 per 100,000).
- At 78 deaths per 100,000, local jail inmates age 55 or older had the highest average suicide rate among all age groups during 2000-19.

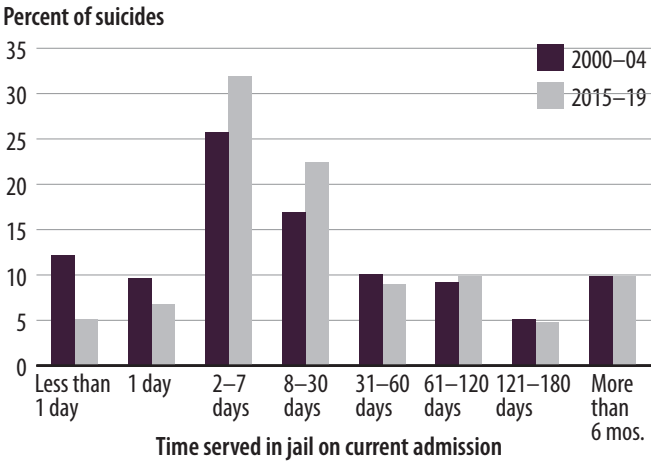
Criminal justice characteristics of local jail inmates who died by suicide

- Unconvicted inmates accounted for almost 77% of those who died by suicide in local jails during 2000-19 **(table 6)**.
- Inmates held for a violent offense accounted for the largest portion of suicides in local jails during the 20-year period and in each of its intervening 5-year periods.
- During 2015-19, about 18% of suicides in local jails were of persons held for assault, and almost 10% were of those held for murder or nonnegligent manslaughter.
- Local jail inmates held for property or public order offenses during 2000-19 each accounted for about 19% of suicides, while those in jail for drug offenses accounted for 10%.
- During 2010-19, about 92% of jail suicides were of persons held for local law enforcement agencies or courts, 6% for state or federal prisons or other authorities, 2% for the U.S. Marshals Service, and 1% for U.S. Immigration and Customs Enforcement.

Circumstances of suicide deaths in local jails

- Two-thirds (66%) of local jail suicides during 2015-19 occurred within the first 30 days of incarceration, and 44% occurred within the first week **(figure 3)**.
- The percentage of jail suicides that occurred in the first 24 hours decreased between the periods of 2000-04 (22%) and 2015-19 (12%).

FIGURE 3
Percent of suicides in local jails, by time served between admission and death, 2000–04 and 2015–19



Note: Excludes deaths in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Details may not sum to totals due to rounding and missing data. Data may have been revised from previously published statistics. See *Methodology*. See table 6 for percentages.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2000–19.

- Jail inmates who had spent more than 6 months in custody made up 10% of suicides in 2015-19.
- Suicides in local jails were less common between 6 a.m. and 12 p.m. than at other times of day **(table 7)**.
- During 2010-19, almost 73% of jail suicides occurred in the person's cell and 8% occurred in jail segregation units.
- During 2010-19, almost 14% of inmates who died by suicide had at least one overnight stay in a mental health services unit since entering jail.

Characteristics of jail facilities with suicides in 2019

- In 2019, a total of 282 local jail facilities, representing 278 jail jurisdictions, reported at least one suicide **(tables 8 and 9)**.
- Twelve percent of jail facilities operated by a private company reported at least one suicide in 2019, compared to 11% for regional jails, 9% for jails operated by counties, and almost 7% for city-operated jails.
- Among jail facilities that reported work or prerelease as one of their jail functions in 2019, 91% did not have a death by suicide during that year.

- The median rated capacity of jails that had two or more suicides in 2019 was 1,296 beds, compared to a median capacity of 305 beds in jails with one suicide and 110 beds in jails with no suicides.
- Almost 13% of jails operating above 100% capacity at midyear 2019 had a suicide during the calendar year, compared to about 8% of jails operating at 100% capacity or less.
- More than half of all jail jurisdictions with an average daily population (ADP) of 1,000 or more inmates in 2019 had at least one suicide that year, and more than 35% of these jurisdictions reported two or more suicides.
- Eleven percent of jail jurisdictions that held 50% or more of their inmates for felonies in 2019 had a death by suicide that year.
- In jail jurisdictions reporting multiple deaths by suicide in 2019, the ratio of inmates to correctional staff was 4.6, compared to 4.4 for jurisdictions with one suicide and 3.8 for jurisdictions with no suicides.

Suicides in state prisons

- From 2001 to 2019, the number of suicides in state prisons increased 85% from 168 to 311, while total deaths from all causes in these facilities grew more than 34% **(table 1)**.
- The number of prisoner suicides in states in the South nearly doubled between 2010-14 (343) and 2015-19 (631) **(table 10)**.
- The number of prisoners who died by suicide between 2010-14 and 2015-19 tripled in three states (Arkansas, Georgia, and West Virginia) and more than doubled in five states (Alabama, Florida, Mississippi, North Carolina, and Tennessee).
- The average annual suicide rate grew from 15 per 100,000 state prisoners to 21 per 100,000 between the 4-year period of 2001-04 and the 5 year period of 2015-2019 **(table 11)**.
- Over the 19 years of data collection on deaths in state prisons, the Northeast (22 per 100,000) had the highest average annual suicide rate, compared to the West (21 per 100,000), Midwest (16 per 100,000), and South (15 per 100,000).

Demographic characteristics of state prisoners who died by suicide

- Almost 95% of all persons in state prison who died by suicide during 2001-19 were male **(table 12)**.
- During 2015-19, 57% of persons in state prison who committed suicide were white, almost 24% were black, and almost 15% were Hispanic.
- State prisoners who were Asian, Native Hawaiian, and Other Pacific Islander and those who were American Indian and Alaska Native each accounted for less than 2% of suicides during 2015-19.
- Among state prisoners who died of suicide, the portion who were age 24 or younger decreased from almost 17% during the 4-year period of 2001-04 to 10% during the 5-year period of 2015-19.
- In state prisons, the suicide rate increased 49% between the 4-year period of 2001-04 and 5-year period of 2015-19 **(table 13)**.
- Asian state prisoners had average suicide rates during 2015-19 that were double those of black or Hispanic state prisoners.
- With the exception of state prisoners age 24 or younger (15 per 100,000), the average suicide rates among all age groups during 2001-19 were between 17 and 19 per 100,000.

Criminal justice characteristics of state prisoners who died by suicide

- Thirty percent of suicides during 2001-19 were of prisoners serving time for murder or nonnegligent manslaughter **(table 14)**.
- Prisoners serving sentences for a drug offense accounted for 8% of suicides during the 4-year period of 2001-04 and 4% during the 5-year period of 2015-19.
- Almost 70% of suicides in state prisons were of prisoners who served more than 1 year under state correctional authority.
- Persons who served more than 10 years in state prison accounted for 13% of suicides in these facilities during 2001-04 and almost 25% during 2015-19 **(figure 4)**.

Circumstances of suicide deaths in state prisons

- As in local jails, the majority of suicides in state prisons during 2010-19 were by suffocation, including hanging and self-strangulation **(table 15)**.
- During 2015-19, almost 76% of suicides of persons in state prison took place in the person's cell or room, 11% in a segregation unit, and 4% in a special medical or mental health services unit.
- About 15% of persons in state prison who died by suicide during 2010-19 had spent at least one night in a mental health facility after admission to prison, while 51% had not, with this characteristic unknown for 32%.

Suicides in federal prisons

- Suicides in federal prisons increased 61%, from 18 in 2001 to 29 in 2019.
- Federal prisons had an average suicide rate of 16 per 100,000 prisoners during 2015-19 **(table 17)**.

Demographic and criminal justice characteristics of federal prisoners who died by suicide

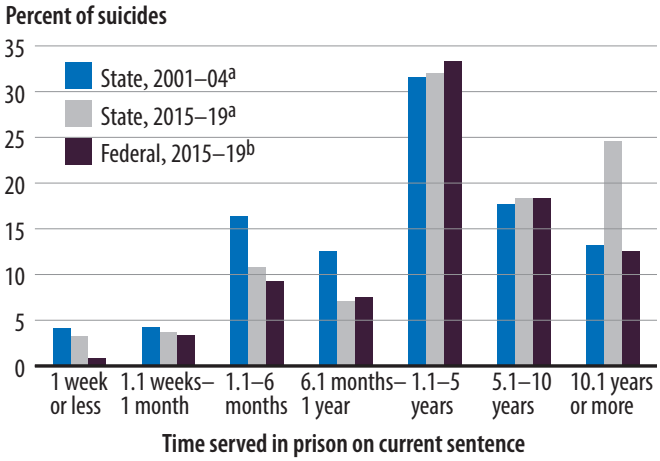
- During 2015-19, males accounted for 98% of suicides among persons in federal prison, and whites accounted for 59% **(table 16)**.
- During 2015-19, white prisoners were 8.5 times as likely as Hispanic prisoners and 5 times as likely as black prisoners to die by suicide in federal prisons on average.
- From 2015-19, 13% of federal prisoners who died by suicide had been sentenced for drug offenses **(table 18)**.
- Almost two-thirds (64%) of federal prisoners who died by suicide during 2015-19 had served more than 1 year of their sentence.
- Death by suffocation accounted for about 81% of all suicides in federal prisons during 2015-19 **(table 19)**.

Characteristics of state and federal prison facilities with suicides in 2019

- Suicides were recorded in 217 state or federal prison facilities in 2019, with 71 of those facilities having multiple suicides **(table 20)**.

FIGURE 4

Percent of suicides in state and federal prisons, by time served between admission and death, 2001–04 and 2015–19



Note: Details may not sum to totals due to rounding and missing data. Data may have been revised from previously published statistics. See *Methodology*. See tables 14 and 18 for percentages.

[a]Includes deaths in publicly and privately operated state facilities and in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont.

[b]Includes deaths in Federal Bureau of Prisons (BOP) facilities and excludes deaths in privately operated federal facilities. As of December 30, 2001, sentenced felons from the District of Columbia were the responsibility of the BOP. See *Methodology*.

Source: Bureau of Justice Statistics, Federal Law Enforcement Agency Deaths in Custody Reporting Program, 2015–2019; and Mortality in Correctional Institutions, 2001–2019.

- In 2019, about 19% of state, 17% of federal, and 12% of privately operated prison facilities under contract to both state and federal authorities experienced one or more suicides.
- Almost 13% of the 979 prison facilities whose main function was general housing of adult prisoners reported a single suicide event during 2019, and another 6% reported two or more suicides.
- The median capacity of prisons that had two or more suicides in 2019 was 1,738 beds, compared to 1,365 beds for facilities reporting one suicide and 927 beds for those with no suicides.
- Eighty-four percent of prisons operating at 100% capacity or less on June 30, 2019, and 77% of facilities operating above 100% capacity, experienced no suicides in the calendar year.
- State and federal prisons holding 2,500 or more prisoners were more likely to report one or more

suicides (45% of these facilities) than prisons with smaller populations **(table 21)**.

- Thirty-five percent of prison facilities whose security level was administrative, maximum, or super maximum had at least one suicide in 2019, compared to 15% of medium security and 4% of minimum security prisons.
- State and federal prisons reporting two or more suicides in 2019 held 11% of prisoners in restricted housing status, while facilities with no suicides held approximately 5% in restricted housing.
- Prisons reporting zero suicides in 2019 had a larger percentage of staff assigned to security duties (73%) than facilities with one suicide or two or more suicides (68% each).

Terms and definitions

Average daily population—The number of inmates in jail each day for a year, divided by the number of days in the year.

Capacity, design—The number of inmates or prisoners a facility can hold, as set by the architect or planner.

Capacity, rated—The number of inmates, prisoners, or beds a facility can hold, as set by a rating official.

Custody count—Inmates held in the physical custody of local jails, or prisoners held in the physical custody of state or federal prisons, regardless of sentence length or which authority has jurisdiction over the person.

Federal prison—The system that houses persons under the jurisdiction of the Federal Bureau of Prisons, which holds adult prisoners in secure federal prison facilities, nonsecure community corrections facilities, and privately operated facilities, and holds persons age 17 or younger in privately operated facilities.

Jail—A confinement facility generally operated under the authority of a sheriff, police chief, or county or city administrator. A small number of jails are privately operated. Regional jails include two or more jail jurisdictions with a formal agreement to operate a jail facility. Facilities include jails, detention centers, county or city correctional centers, special jail facilities (such as medical or treatment centers and prerelease centers), and temporary holding or lockup facilities that are part of a facility's combined function. Jails are intended for adults but can hold juveniles before or after their cases are adjudicated.

Jails—

- hold inmates sentenced to jail facilities who usually have a sentence of 1 year or less
- receive individuals pending arraignment and hold them as they await trial, conviction, or sentencing
- readmit probation, parole, and bail bond violators and absconders
- detain juveniles pending their transfer to juvenile authorities
- hold mentally ill persons pending their movement to appropriate mental health facilities
- hold individuals for the military, for protective custody, as witnesses for courts, and for contempt of court
- release convicted inmates to the community on completion of sentence
- transfer inmates to federal, state, or other authorities
- house inmates for federal, state, or other authorities due to crowding of their facilities
- operate community-based programs as alternatives to incarceration.

Jail jurisdiction—A county (parish in Louisiana) or municipal government that administers one or more local jails and represents the entity responsible for managing jail facilities under its authority.

Jail reporting unit—Most jail jurisdictions consist of a single facility, but some have multiple facilities, or multiple facility operators, called reporting units. For example, a single jail jurisdiction may have legal authority over five jail facilities, with four managed by a single operator and one managed by a different operator (i.e., one jail jurisdiction with two reporting units and five jail facilities).

Prison—A long-term confinement facility that is run by a state or the federal government and typically holds felons, or offenders with sentences of more than 1 year imposed by state or federal courts. Sentence length may vary by state. Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont each operate an integrated system that combines prisons and jails, and all of their inmates are counted in this report as prisoners. Prisoners under the jurisdiction of state or federal correctional officials can be held in publicly or privately operated secure or nonsecure facilities, including state or federal prisons, boot camps, halfway houses, treatment facilities, hospitals, local jails, or another state's facilities.

Prison jurisdiction—The legal authority of state or federal correctional officials over a prisoner, regardless of where the prisoner is held.

Suicide—A self-inflicted death by—

- suffocation, including hanging, strangulation, asphyxia, anoxia, and other methods of reducing oxygen intake
- exsanguination, including all types of sharp force trauma or other injuries that cause acute loss of blood
- poisoning, including drug overdoses
- firearm
- other methods, including self-inflicted blunt force trauma, dehydration, and unknown or unreported causes.

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TABLE 1

Total deaths and number and rate of suicides in local jails and state and federal prisons, 2000–2019

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Local jails																				
Total deaths	903	942	969	1,001	1,021	1,045	1,094	1,099	959	961	918	888	960	987	1,053	1,096	1,076	1,103	1,138	1,200
Suicides	289	313	314	296	299	286	278	283	228	304	305	311	301	328	368	369	334	317	339	355
Suicide rate per 100,000 local jail inmates[a]	48	49	47	43	42	39	36	36	29	41	42	43	40	46	50	52	47	43	46	49
State prisons																				
Total deaths	/	2,869	2,935	3,152	3,123	3,168	3,233	3,389	3,452	3,417	3,233	3,351	3,357	3,478	3,484	3,708	3,734	3,954	4,137	3,848
Suicides	/	168	168	199	199	213	219	215	197	202	215	185	205	192	249	219	254	261	312	311
Suicide rate per 100,000 state prisoners[b]	:	14	14	16	16	17	17	16	15	15	16	14	16	15	20	18	21	22	26	27
Federal prisons[c]																				
Total deaths	/	301	335	346	333	388	328	368	399	376	387	387	350	400	444	455	388	381	378	381
Suicides	/	18	17	6	11	13	12	18	21	21	11	17	19	14	24	20	18	24	29	29
Suicide rate per 100,000 federal prisoners[b]	:	13	12	4	7	8	7	11	13	12	6	10	11	8	14	12	12	16	19	20

Note: Jail counts exclude and state prison counts include deaths in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Data may have been revised from previously published statistics. See *Methodology*.

:Not calculated.

/Not collected.

[a]Based on the annual number of suicides and the average daily population (ADP) in local jails. In 2000, the ADP was estimated by taking the average of January 1 and December 31 inmate population counts.

[b]Based on the annual number of suicides and the December 31 custody population in state or federal prisons.

[c]Includes deaths in Federal Bureau of Prisons (BOP) facilities and excludes deaths in privately operated federal facilities. From 2001 to 2014, the BOP provided an aggregate count of deaths in BOP-operated facilities, by cause of death. From 2015 to 2019, the BOP provided individual-level death records from both BOP- and privately operated federal facilities. To allow for comparability over time, nine deaths in private federal prisons in 2015, seven in 2016, seven in 2017, five in 2018, and nine in 2019 were excluded. Among these deaths, one suicide was in 2015, one in 2016, and none in 2017, 2018, and 2019. As of December 30, 2001, sentenced felons from the District of Columbia were the responsibility of the BOP. See *Methodology*.

Source: Bureau of Justice Statistics, Federal Law Enforcement Agency Deaths in Custody Reporting Program, 2015–2019; Mortality in Correctional Institutions, 2000–2019; and National Prisoner Statistics program, 2001–2019.

TABLE 2
Aggregated number of suicides in local jails, by state and region, 2000–19

	2000–04	2005–09	2010–14	2015–19	2000–19
U.S. total	1,511	1,379	1,613	1,714	6,217
Northeast	194	171	199	201	765
Maine	7	6	8	6	27
Massachusetts	14	18	22	26	80
New Hampshire	8	8	7	10	33
New Jersey	26	30	33	27	116
New York	55	42	53	34	184
Pennsylvania	84	67	76	98	325
Midwest	316	288	356	390	1,350
Illinois	43	42	42	42	169
Indiana	29	31	45	49	154
Iowa	9	12	13	12	46
Kansas	39	23	23	28	113
Michigan	44	40	50	38	172
Minnesota	21	12	17	30	80
Missouri	36	36	52	51	175
Nebraska	15	10	8	12	45
North Dakota	4	5	5	4	18
Ohio	52	51	65	76	244
South Dakota	4	5	3	7	19
Wisconsin	20	21	33	41	115
South	654	598	655	701	2,608
Alabama	40	34	36	37	147
Arkansas	34	16	26	20	96
District of Columbia	1	4	5	5	15
Florida	63	82	94	94	333
Georgia	75	68	66	73	282
Kentucky	21	21	23	15	80
Louisiana	25	30	28	34	117
Maryland	33	37	36	38	144
Mississippi	28	33	27	29	117
North Carolina	41	31	41	62	175
Oklahoma	28	28	25	32	113
South Carolina	16	17	29	26	88
Tennessee	38	48	41	59	186
Texas	135	94	114	105	448
Virginia	66	53	51	57	227
West Virginia	10	2	13	15	40
West	347	322	403	422	1,494
Arizona	29	26	25	39	119
California	156	132	167	160	615
Colorado	35	45	28	59	167
Idaho	6	12	16	8	42
Montana	11	10	18	10	49
Nevada	27	13	19	25	84
New Mexico	23	12	28	18	81
Oregon	15	10	16	22	63
Utah	21	25	32	31	109
Washington	17	33	48	42	140
Wyoming	7	4	6	8	25

Note: For details on regions, see U.S. Census Bureau. (n.d.). *Census regions and divisions of the United States.* https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf. Excludes deaths in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Data may have been revised from previously published statistics. See *Methodology*.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2000–19.

TABLE 3
Average rate of suicides per 100,000 inmates in local jails, by state and region, 2000–19

	2000–04	2005–09	2010–14	2015–19	2000–19
U.S. total	46	36	44	48	43
Northeast	42	33	42	50	41
Maine	96 !	74 !	131 !	82 !	94
Massachusetts	24	27	43	53	36
New Hampshire	114 !	80 !	67 !	118 !	91
New Jersey	32	33	42	48	38
New York	37	27	38	31	33
Pennsylvania	54	36	41	58	47
Midwest	56	45	58	63	55
Illinois	43	38	40	48	42
Indiana	38	35	53	52	44
Iowa	52 !	59	63	51	56
Kansas	125	62	63	73	79
Michigan	53	44	59	47	51
Minnesota	70	33	52	85	60
Missouri	82	65	90	84	80
Nebraska	122	66	46 !	62	70
North Dakota	108 !	106 !	87 !	54 !	83
Ohio	57	51	71	78	64
South Dakota	62 !	64 !	36 !	71 !	58
Wisconsin	29	29	50	63	42
South	41	32	36	38	37
Alabama	62	45	50	49	51
Arkansas	116	47	71	46	67
District of Columbia	8 !	27 !	39 !	53 !	30
Florida	24	26	34	35	29
Georgia	40	30	31	36	34
Kentucky	28	24	25	13	21
Louisiana	19	21	18	23	20
Maryland	56	56	60	82	62
Mississippi	55	60	47	43	51
North Carolina	57	34	44	64	49
Oklahoma	71	53	51	55	57
South Carolina	30	26	49	46	38
Tennessee	35	36	34	41	37
Texas	46	29	35	31	35
Virginia	57	37	35	41	42
West Virginia	62	10 !	62	64	49
West	49	40	53	56	49
Arizona	44	33	36	59	42
California	42	32	43	42	40
Colorado	65	67	46	93	68
Idaho	39 !	61	88	39 !	57
Montana	123	108	179	79	120
Nevada	88	37	54	70	61
New Mexico	67	27	66	51	52
Oregon	44	29	51	70	48
Utah	71	74	90	85	80

Continued on next page

TABLE 3 (continued)

Average rate of suicides per 100,000 inmates in local jails, by state and region, 2000–19

	2000–04	2005–09	2010–14	2015–19	2000–19
Washington	30	50	79	70	57
Wyoming	115 !	50 !	77 !	109 !	86

Note: For details on regions, see U.S. Census Bureau. (n.d.). *Census regions and divisions of the United States.* https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf. Rates are based on the annual number of suicides and the average daily population (ADP) in local jails. In 2000, the ADP was estimated by taking the average of January 1 and December 31 inmate population counts. Excludes deaths and populations in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Data may have been revised from previously published statistics. See *Methodology*.

! Interpret with caution. Estimate is based on 10 or fewer cases.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2000–19.

TABLE 4

Percent of suicides in local jails, by demographic characteristics of inmates, 2000–19

Inmate characteristic	2000–04	2005–09	2010–14	2015–19	2000–19
Total suicides	1,511	1,379	1,613	1,714	6,217
Sex	100%	100%	100%	100%	100%
Male	91.7	92.2	90.5	88.1	90.5
Female	8.2	7.8	9.5	11.9	9.5
Race/ethnicity	100%	100%	100%	100%	100%
White[a]	70.5	69.2	71.5	74.0	71.4
Black[a]	14.1	15.0	13.0	11.3	13.2
Hispanic	12.2	11.0	11.8	11.5	11.6
American Indian/Alaska Native[a]	1.6	2.6	2.0	1.6	1.9
Asian/Native Hawaiian/Other Pacific Islander[a]	1.3	1.4	0.9	1.2	1.2
Other[a,b]	0.1	0.3	0.6	0.2	0.3
Age	100%	100%	100%	100%	100%
24 or younger	22.9	19.6	16.0	11.0	17.1
25–34	31.2	28.8	32.8	32.9	31.5
35–44	30.1	30.0	26.2	28.6	28.6
45–54	12.3	16.5	17.6	18.4	16.3
55 or older	3.3	4.9	7.3	9.0	6.3

Note: Excludes deaths in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Details may not sum to totals due to rounding and missing data. Data may have been revised from previously published statistics. See *Methodology*.

[a]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[b]Includes persons of two or more races or other unspecified races.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2000–19.

TABLE 5

Average rate of suicides per 100,000 inmates in local jails, by demographic characteristics of inmates, 2000–19

Inmate characteristic	2000–04	2005–09	2010–14	2015–19	2000–19
Total	46	36	44	48	43
Sex					
Male	48	38	46	49	45
Female	32	22	32	38	31
Race/ethnicity					
White[a]	90	70	91	93	86
Black[a]	16	15	18	18	16
Hispanic	30	21	24	26	25
American Indian/Alaska Native[a]	56	72	54	47	57
Asian/Native Hawaiian/Other Pacific Islander[a]	52	48	43	63	52
Other[a,b]	1 !	2 !	3 !	1 !	2
Age					
24 or younger	36	25	27	20	27
25–34	44	33	43	45	41
35–44	53	46	55	65	54
45–54	53	45	56	62	54
55 or older	65	55	80	103	78

Note: Rates are based on the annual number of suicides and the average daily population (ADP) in local jails. In 2000, the ADP was estimated by taking the average of January 1 and December 31 inmate population counts. Excludes deaths in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Data may have been revised from previously published statistics. See *Methodology*.

! Interpret with caution. Estimate is based on 10 or fewer cases.

[a]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[b]Includes persons of two or more races or other unspecified races.

Source: Bureau of Justice Statistics, Annual Survey of Jails, 2000–19; Mortality in Correctional Institutions, 2000–19; National Inmate Survey, 2007–09 and 2011–12; and Survey of Inmates in Local Jails, 2002.

TABLE 6

Percent of suicides in local jails, by criminal justice characteristics of inmates, 2000–19

Inmate characteristic	2000–04	2005–09	2010–14	2015–19	2000–19
Total suicides	1,511	1,379	1,613	1,714	6,217
Legal status	100%	100%	100%	100%	100%
Convicted	18.3	16.8	16.9	19.2	17.8
Unconvicted	72.7	75.0	79.3	79.2	76.7
Other/unknown	9.0	8.3	3.8	1.6	5.5
Most serious offense[a]	100%	100%	100%	100%	100%
Violent	47.8	47.6	49.5	46.9	48.0
Murder[b]	12.0	10.8	10.0	9.7	10.6
Kidnapping	3.6	3.1	4.1	3.3	3.5
Rape/sexual assault	8.9	8.9	9.1	8.8	8.9
Robbery	5.2	5.6	5.4	4.0	5.0
Assault	13.9	17.0	18.4	18.1	16.9
Other	4.2	2.4	2.5	3.1	3.1
Property	18.6	18.4	19.1	18.1	18.6
Burglary	6.2	6.6	6.1	5.4	6.1
Larceny/theft	7.4	7.6	9.1	7.6	7.9
Motor vehicle theft	1.3	0.8	0.9	1.3	1.1
Arson	0.7	0.8	0.7	0.5	0.7
Fraud	3.1	2.5	2.2	3.4	2.8
Drugs	10.9	8.3	9.7	11.9	10.3
Possession	5.8	3.8	4.5	6.2	5.1
Trafficking	3.7	2.5	3.1	4.0	3.4
Other/unknown	1.4	2.0	2.2	1.8	1.8
Public order	20.1	20.4	17.9	19.2	19.3
Weapons offense	1.4	0.9	1.1	1.1	1.1
Obstruction of justice	3.3	3.9	3.5	5.4	4.1
DUI/DWI	2.3	2.8	2.2	1.8	2.2
Traffic offense excluding DUI/DWI	2.7	2.3	1.7	1.2	1.9
Probation/parole violation and escape	6.5	6.6	6.0	6.9	6.5
Other	3.9	4.0	3.5	2.7	3.5
Other offenses/unreported	2.7	5.3	3.7	3.9	3.9
Time served in jail on current admission	100%	100%	100%	100%	100%
Less than 1 day	12.2	9.5	7.3	5.1	8.4
1 day	9.6	9.4	10.0	6.8	8.9
2–7 days	25.7	28.7	30.1	31.9	29.2
8–30 days	16.9	14.9	19.7	22.4	18.7
31–60 days	10.1	10.5	8.4	9.0	9.5
61–120 days	9.2	11.9	10.0	9.9	10.2
121–180 days	5.1	5.0	3.7	4.8	4.6
More than 6 months	9.9	9.4	10.6	9.9	10.0
Hold status[c]	/	/	100%	100%	100%
Local law enforcement/court	/	/	94.5	88.9	91.6
U.S. Immigration and Customs Enforcement	/	/	0.8	0.8	0.8
U.S. Marshals Service	/	/	1.4	2.5	2.0
Other authority[d]	/	/	3.4	7.8	5.7

Note: Excludes deaths in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Details may not sum to totals due to rounding and missing data. Data may have been revised from previously published statistics. See *Methodology*.

/Not collected.

[a]Refers to the most serious offense for which the individual is being held in jail, where violent offenses are most serious, followed by property, drug, public order, and all other offenses.

[b]Includes nonnegligent manslaughter.

[c]Includes contractual, temporary, courtesy, or ad hoc holds for federal, local, or state authorities. A jail inmate may have multiple hold statuses. The 2000–19 category reflects 2010–19 percentages because these data were first collected in 2010.

[d]Includes state or federal prison, the Bureau of Indian Affairs, or any other jail jurisdiction.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2000–19.

TABLE 7

Percent of suicides in local jails, by circumstances of death, 2000–19

Circumstance of death	2000–04	2005–09	2010–14	2015–19	2000–19
Total suicides	1,511	1,379	1,613	1,714	6,217
Time of death	100%	100%	100%	100%	100%
Morning (6 a.m.–12 p.m.)	18.9	20.5	20.8	18.8	19.7
Afternoon (12 p.m.–6 p.m.)	25.0	26.9	28.8	31.3	28.2
Evening (6 p.m.–12 a.m.)	27.0	26.3	27.8	26.4	26.9
Overnight (12 a.m.–6 a.m.)	27.2	23.7	21.6	22.2	23.6
Method of suicide	/	/	100%	100%	100%
Suffocation[a]	/	/	85.6	91.4	88.6
Exsanguination[b]	/	/	1.4	1.2	1.3
Poisoning[c]	/	/	2.1	0.9	1.5
Firearm	/	/	0.7	0.3	0.5
Other[d]	/	/	10.2	6.2	8.2
Location of suicide event[e]	100%	100%	100%	100%	100%
Inmate's cell/room	79.4	80.1	72.5	72.6	72.5
Temporary housing	9.1	8.6	6.1	5.5	5.8
Common area within jail facility[f]	4.0	4.2	4.2	4.5	4.3
Segregation unit	/	/	8.1	8.1	8.1
Special medical unit/infirmary	/	/	3.3	3.0	3.2
Special mental health services unit	/	/	1.0	1.3	1.1
Elsewhere within jail facility	/	/	1.7	1.9	1.8
Outside of jail facility	1.1	0.6	0.6	0.9	0.8
Other	5.2	5.2	1.9	0.6	1.3
Inmate had an overnight stay in a mental health facility after jail admission	/	/	100%	100%	100%
Yes	/	/	14.3	13.6	13.9
No	/	/	71.4	72.2	71.8
Unknown	/	/	14.1	14.1	14.1

Note: Excludes deaths in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Details may not sum to totals due to rounding and missing data. Data may have been revised from previously published statistics. The 2000–19 category reflects 2010–19 percentages because data were first collected in 2010. See *Methodology*.

/Not collected.

[a]Includes hanging, strangulation, asphyxia, anoxia, and other methods of reducing oxygen intake.

[b]Includes all types of sharp force trauma or other injuries that cause acute loss of blood.

[c]Includes drug overdoses and ingestion or use of other poisonous substances.

[d]Includes self-inflicted blunt force trauma, dehydration, and unknown or unreported causes.

[e]Location where inmate attempted to commit suicide. May not reflect actual location of death.

[f]Includes temporary holding areas or lockups and common areas within the facility, such as jail yards, cafeterias, or kitchens.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2000–19.

TABLE 8
Percent of local jails, by number of suicides and facility characteristics, 2019

Facility characteristic	Number of jail facilities	Total	No suicides	1 suicide	2 or more suicides
Total	3,116	3,116	2,834	226	56
Jail operator					
County	2,693	100%	90.8%	7.4%	1.8%
City	310	100%	93.1	5.3	1.7
Regional	79	100%	89.3	10.7	0.0
Private	34	100%	87.7	3.4	8.9
Inmate sex					
Both male and female	2,763	100%	90.5%	7.7%	1.9%
Female only	10	100%	90.5	9.6	0.0
Male only	276	100%	95.0	3.9	1.1
Jail purpose[a]					
Temporary holding place for detainment of up to 72 hours	1,659	100%	91.3%	7.0%	1.8%
Detention facility with authority to hold for more than 72 hours	2,864	100%	90.7	7.4	1.9
Correctional facility for felons with sentences of more than 1 year	1,027	100%	88.2	9.3	2.5
Jail function[b]					
General adult confinement	3,032	100%	90.8%	7.4%	1.8%
Confinement of persons returned to custody	2,897	100%	90.5	7.6	1.9
Work release/prerelease	1,603	100%	91.4	6.8	1.8
Reception/diagnosis/classification	1,627	100%	88.5	8.8	2.7
Juvenile confinement	339	100%	83.5	10.5	6.0
Medical treatment/hospitalization	655	100%	83.1	11.9	5.0
Mental health/psychiatric care	794	100%	83.8	11.6	4.5
Alcohol treatment	472	100%	85.4	10.3	4.2
Drug treatment	513	100%	84.9	11.0	4.1
Boot camp	9	100%	77.8	0.0	22.2
Protective custody	1,152	100%	86.4	10.3	3.3
Capacity[b]					
Jail facilities operating at 100% capacity or less	2,646	100%	91.5%	6.9%	1.6%
Jail facilities operating at more than 100% capacity	470	100%	87.3	9.5	3.2
Median rated capacity			110 beds	305 beds	1,296 beds
Mean rated capacity			244.4	561.5	1,540.4

Note: See *Terms and definitions* for the distinctions between jail jurisdictions, jail reporting units, and jail facilities. Includes jails with a suicide in their facilities, single-jail jurisdictions with a suicide whose location of death was at an outside medical facility or hospital, and multiple-jail jurisdictions with a suicide whose location of death was outside the facility but whose death record specified a facility associated with that death. Excludes one facility and seven jurisdictions for which the suicide could not be linked to a specific jail facility in the 2019 Census of Local Jails. Excludes deaths in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Details may not sum to totals due to rounding and missing data. Data may have been revised from previously published statistics. See *Methodology*.

[a]Jail facilities can have multiple purposes and functions.

[b]As of midyear (last weekday in June). Facilities operating above 100% capacity held more inmates than their rated or design capacity. See *Terms and definitions*.

Source: Bureau of Justice Statistics, Census of Local Jails, 2019; and Mortality in Correctional Institutions, 2019.

TABLE 9

Percent of local jail jurisdictions, by number of suicides and population characteristics, 2019

Population characteristic	Number of jail jurisdictions	Total	No suicides	1 suicide	2 or more suicides
Total	2,845	2,845	2,566	217	61
Average daily population					
49 or fewer inmates	1,002	100%	97.2%	2.8%	<0.1%
50–99	514	100%	95.0	4.8	0.2
100–249	643	100%	91.3	7.5	1.1
250–499	348	100%	84.4	13.2	1.2
500–999	202	100%	77.6	19.7	2.7
1,000–2,499	113	100%	49.1	23.1	27.8
2,500 or more	23	100%	46.1	18.1	35.8
Felony status					
50% or more are felons	2,026	100%	89.5%	8.0%	2.6%
Less than 50% are felons	819	100%	92.0	6.9	1.1
Conviction status					
50% or more are unconvicted	2,105	100%	89.2%	8.3%	2.5%
Less than 50% are unconvicted	740	100%	93.0	5.9	1.1
Inmates per correctional staff member			3.8 inmates	4.4 inmates	4.6 inmates
Inmates per any staff member			3.0 inmates	3.4 inmates	3.6 inmates
Annual admissions per inmate in custody on June 30, 2019*			15 admissions	14 admissions	11 admissions

Note: See *Terms and definitions* for the distinctions between jail jurisdictions, jail reporting units, and jail facilities. Details may not sum to totals due to rounding and missing data. Excludes deaths in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Data may have been revised from previously published statistics. See *Methodology*.

*Includes persons officially booked into jail facilities by a formal legal document and the authority of the courts or some other official agency, repeat offenders booked on new charges, and persons serving weekend sentences when they come into jail for the first weekend.

Source: Bureau of Justice Statistics, Census of Local Jails, 2019; and Mortality in Correctional Institutions, 2019.

TABLE 10
Aggregated number of suicides in state and federal prisons, by state and region, 2001–19

	2001–04	2005–09	2010–14	2015–19	2001–19
U.S. total	786	1,131	1,131	1,477	4,525
Federal	52	85	85	120	342
State total	734	1,046	1,046	1,357	4,183
Northeast	124	183	194	196	697
Connecticut	22	20	18	20	80
Delaware	6	9	10	8	33
Maine	1	1	1	1	4
Massachusetts	4	21	22	14	61
New Hampshire	7	1	3	1	12
New Jersey	10	20	16	7	53
New York	43	64	71	69	247
Pennsylvania	19	41	43	66	169
Rhode Island	7	6	8	6	27
Vermont	5	0	2	4	11
Midwest	162	196	202	225	785
Illinois	32	33	37	35	137
Indiana	14	25	18	30	87
Iowa	10	6	9	9	34
Kansas	9	3	6	13	31
Michigan	26	34	48	26	134
Minnesota	7	8	7	5	27
Missouri	10	26	16	20	72
Nebraska	1	2	10	7	20
North Dakota	1	0	0	3	4
Ohio	24	30	35	45	134
South Dakota	5	3	5	4	17
Wisconsin	23	26	11	28	88
South	232	371	343	631	1,577
Alabama	4	6	10	26	46
Arkansas	11	13	8	31	63
Florida	19	43	39	96	197
Georgia	22	30	19	74	145
Kentucky	4	7	6	8	25
Louisiana	3	12	11	16	42
Maryland	19	29	16	18	82
Mississippi	8	12	10	28	58
North Carolina	12	14	11	31	68
Oklahoma	6	26	30	30	92
South Carolina	7	13	20	39	79
Tennessee	8	20	14	35	77
Texas	91	133	133	170	527
Virginia	15	13	14	23	65
West Virginia	3	0	2	6	11
West	216	296	307	305	1,124
Alaska	6	7	9	14	36
Arizona	16	32	40	35	123
California	114	172	162	148	596
Colorado	13	17	23	26	79
Hawaii	8	7	7	6	28
Idaho	8	7	11	13	39
Montana	5	4	5	5	19

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TABLE 10 (continued)
Aggregated number of suicides in state and federal prisons, by state and region, 2001–19

	2001–04	2005–09	2010–14	2015–19	2001–19
Nevada	6	11	11	12	40
New Mexico	6	9	6	8	29
Oregon	10	11	9	7	37
Utah	11	10	10	10	41
Washington	11	8	12	17	48
Wyoming	2	1	2	4	9

Note: For details on regions, see U.S. Census Bureau. (n.d.). *Census regions and divisions of the United States.* https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf. State counts include deaths in publicly and privately operated state facilities and in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Federal counts include deaths in Federal Bureau of Prisons (BOP) facilities and exclude deaths in privately operated federal facilities. As of December 30, 2001, sentenced felons from the District of Columbia were the responsibility of the BOP. Data may have been revised from previously published statistics. See *Methodology*.

Source: Bureau of Justice Statistics, Federal Law Enforcement Agency Deaths in Custody Reporting Program, 2015–19; Mortality in Correctional Institutions, 2001–19; and National Prisoner Statistics program, 2001–14.

TABLE 11
Average rate of suicides per 100,000 prisoners in state and federal prisons, by state and region, 2001–19

	2001–04	2005–09	2010–14	2015–19	2001–19
U.S. total	14	15	15	21	16
Federal	8	9	8	13	9
State total	15	16	16	22	18
Northeast	18	20	23	26	22
Connecticut	30	21	21	28	25
Delaware	22 !	26 !	30 !	27 !	27
Maine	13 !	10 !	10 !	9 !	10 !
Massachusetts	10 !	39	40	32	32
New Hampshire	72 !	7 !	23 !	8 !	24
New Jersey	10 !	16	14	7 !	12
New York	16	21	26	29	23
Pennsylvania	12	18	17	28	19
Rhode Island	52 !	33 !	51 !	44 !	44 !
Vermont	80 !	0	20 !	49 !	31 !
Midwest	17	15	15	18	16
Illinois	18	15	15	17	16
Indiana	17	20	13	22	18
Iowa	30 !	14 !	20 !	20 !	20
Kansas	25 !	7 !	13 !	27	18
Michigan	13	14	22	13	16
Minnesota	24 !	18 !	15 !	11 !	16
Missouri	8 !	17	10	13	12
Nebraska	6 !	9 !	41 !	27 !	23
North Dakota	23 !	0	0	36 !	15 !
Ohio	13	12	14	18	14
South Dakota	42 !	18 !	28 !	21 !	26
Wisconsin	27	23	10	24	21
South	11	13	12	24	15
Alabama	4 !	5 !	7 !	23	10
Arkansas	23	20	11	39	24
Florida	6	9	8	20	11
Georgia	11	11	8	31	15
Kentucky	8	9	9	13	10
Louisiana	4	12	12	20	12
Maryland	20	26	14	18	20
Mississippi	13 !	14	13 !	41	20
North Carolina	9	7	6	17	10
Oklahoma	7 !	22	24	22	20
South Carolina	8 !	11	18	40	19
Tennessee	11 !	21	14	34	21
Texas	15	17	17	23	18
Virginia	12	8	9	15	11
West Virginia	20 !	0	7 !	20 !	12
West	19	19	22	23	21
Alaska	33 !	27 !	31 !	61	38
Arizona	13	17	20	17	17
California	18	20	23	23	21
Colorado	17	15	22	26	20
Hawaii	38 !	26 !	26 !	23 !	28
Idaho	36 !	20 !	30	34	30
Montana	44 !	27 !	32 !	29 !	32

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TABLE 11 (continued)
Average rate of suicides per 100,000 prisoners in state and federal prisons, by state and region, 2001–19

	2001–04	2005–09	2010–14	2015–19	2001–19
Nevada	14 !	17	18	18	17
New Mexico	25 !	28 !	18 !	23 !	23
Oregon	21 !	16	13 !	10 !	14
Utah	62	39 !	37 !	41 !	43
Washington	17	9 !	14	19	15
Wyoming	31 !	11 !	18 !	33 !	23 !

Note: For details on regions, see U.S. Census Bureau. (n.d.). *Census regions and divisions of the United States.* https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf. Rates are based on the annual number of suicides and the December 31 custody population in state or federal prisons. State rates include deaths and populations in publicly and privately operated state facilities and in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Federal rates include deaths and populations in Federal Bureau of Prisons (BOP) facilities and exclude deaths and populations in privately operated federal facilities. As of December 30, 2001, sentenced felons from the District of Columbia were the responsibility of the BOP. Data may have been revised from previously published statistics. See *Methodology*.

! Interpret with caution. Estimate is based on 10 or fewer cases.

Source: Bureau of Justice Statistics, Federal Law Enforcement Agency Deaths in Custody Reporting Program, 2015–19; Mortality in Correctional Institutions, 2001–19; and National Prisoner Statistics program, 2001–19.

TABLE 12
Percent of suicides in state prisons, by demographic characteristics of prisoners, 2001–19

Prisoner characteristic	2001–04	2005–09	2010–14	2015–19	2001–19
Total suicides	734	1,046	1,046	1,357	4,183
Sex	100%	100%	100%	100%	100%
Male	94.7	95.5	93.8	95.1	94.8
Female	5.3	4.5	6.2	4.9	5.2
Race/ethnicity	100%	100%	100%	100%	100%
White[a]	57.4	59.3	60.1	57.0	58.4
Black[a]	23.2	19.5	18.7	23.7	21.3
Hispanic	15.0	17.6	15.6	14.7	15.7
American Indian/Alaska Native[a]	1.2	1.1	2.3	1.8	1.7
Asian/Native Hawaiian/Other Pacific Islander[a]	2.2	1.9	2.6	1.9	2.1
Other[a,b]	0.7	0.3	0.2	0.4	0.4
Age	100%	100%	100%	100%	100%
24 or younger	16.9	13.6	11.1	10.5	12.5
25–34	35.6	31.7	31.1	31.0	32.0
35–44	29.0	29.9	25.9	29.7	28.7
45–54	13.8	18.4	21.5	17.5	18.1
55 or older	4.8	6.4	10.4	11.2	8.7

Note: Includes deaths in publicly and privately operated state facilities and in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Details may not sum to totals due to rounding and missing data. As of December 30, 2001, sentenced felons from the District of Columbia were the responsibility of the Federal Bureau of Prisons. Data may have been revised from previously published statistics. See *Methodology*.

[a]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[b]Includes persons of two or more races or other unspecified races.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001–19.

TABLE 13
Average rate of suicides per 100,000 prisoners in state prisons, by demographic characteristics of prisoners, 2001–19

Prisoner characteristic	2001–04	2005–09	2010–14	2015–19	2001–19
Total	15	16	16	22	18
Sex					
Male	15	16	16	23	18
Female	12	10	15	15	13
Race/ethnicity					
White[a]	25	28	30	41	31
Black[a]	8	8	9	16	10
Hispanic	12	15	13	15	14
American Indian/Alaska Native[a]	11 !	11	28	29	19
Asian/Native Hawaiian/Other Pacific Islander[a]	33	32	40	36	35
Other[a,b]	3 !	1 !	<0.5 !	1 !	1 !
Age					
24 or younger	14	14	13	23	15
25–34	16	7	15	21	17
35–44	15	18	17	25	18
45–54	15	27	19	22	18
55 or older	16	48	19	20	19

Note: Rates are based on the annual number of suicides and the December 31 custody population in state prisons. Includes deaths and populations in publicly and privately operated state facilities and in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. As of December 30, 2001, sentenced felons from the District of Columbia were the responsibility of the Federal Bureau of Prisons. Data may have been revised from previously published statistics. See *Methodology*.

! Interpret with caution. Estimate is based on 10 or fewer cases.

[a]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[b]Includes persons of two or more races or other unspecified races.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001–19; and National Prisoner Statistics program, 2001–19.

TABLE 14

Percent of suicides in state prisons, by criminal justice characteristics of prisoners, 2001–19

Prisoner characteristic	2001–04	2005–09	2010–14	2015–19	2001–19
Total suicides	734	1,046	1,046	1,357	4,183
Most serious offense[a]	100%	100%	100%	100%	100%
Violent	69.1	71.4	74.3	71.9	71.9
Murder[b]	26.3	29.3	32.9	29.0	29.6
Kidnapping	3.5	2.7	3.0	3.7	3.2
Rape/sexual assault	15.0	14.9	14.3	13.5	14.3
Robbery	11.0	9.8	11.5	11.9	11.1
Assault	11.2	13.1	11.5	12.2	12.1
Other	2.0	1.7	1.2	1.6	1.6
Property	16.9	14.5	15.0	14.1	14.9
Burglary	9.1	8.0	7.9	7.7	8.1
Larceny/theft	3.4	2.5	3.4	3.8	3.3
Motor vehicle theft	1.2	1.0	0.8	0.7	0.9
Arson	0.8	1.4	1.4	1.0	1.2
Fraud	2.3	1.6	1.5	1.0	1.5
Drugs	8.5	5.8	4.3	4.4	5.4
Possession	2.7	2.6	2.2	2.1	2.3
Trafficking	4.8	2.4	1.4	2.0	2.4
Other/unknown	1.0	0.9	0.7	0.3	0.7
Public order	4.0	5.9	4.7	7.7	5.9
Weapons offense	1.2	1.4	1.7	2.1	1.7
Obstruction of justice	0.7	0.8	0.7	1.6	1.0
DUI/DWI	0.7	1.2	0.7	1.0	0.9
Traffic offense excluding DUI/DWI	0.4	0.2	0.1	0.2	0.2
Probation/parole violation and escape	0.4	1.4	0.6	1.0	0.9
Other	0.5	1.0	1.0	1.8	1.2
Other offenses/unknown	1.6	2.3	1.7	2.0	1.9
Time served in prison on current sentence	100%	100%	100%	100%	100%
1 week or less	4.1	3.6	2.9	3.2	3.4
1.1 weeks–1 month	4.2	4.8	4.8	3.7	4.3
1.1–6 months	16.4	13.6	11.7	10.8	12.7
6.1 months–1 year	12.5	10.7	8.6	7.0	9.3
1.1–5 years	31.6	29.3	30.4	32.0	30.8
5.1–10 years	17.7	18.3	17.1	18.3	17.9
10.1 years or more	13.2	19.5	24.2	24.6	21.2

Note: Includes deaths in publicly and privately operated state facilities and in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. As of December 30, 2001, sentenced felons from the District of Columbia were the responsibility of the Federal Bureau of Prisons. Details may not sum to totals due to rounding and missing data. Data may have been revised from previously published statistics. See *Methodology*.

[a]For prisoners convicted of more than one crime, the most serious offense is the one that carries the longest sentence.

[b]Includes nonnegligent manslaughter.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001–19.

TABLE 15
Percent of suicides in state prisons, by circumstances of death, 2001–19

Circumstance of death	2001–04	2005–09	2010–14	2015–19	2001–19
Total suicides	734	1,046	1,046	1,357	4,183
Time of death	100%	100%	100%	100%	100%
Morning (6 a.m.–12 p.m.)	19.6	22.8	24.4	24.8	23.3
Afternoon (12 p.m.–6 p.m.)	27.1	27.9	28.0	29.6	28.4
Evening (6 p.m.–12 a.m.)	24.5	25.3	25.1	25.9	25.3
Overnight (12 a.m.–6 a.m.)	23.2	20.6	20.9	18.3	20.4
Method of suicide	/	/	100%	100%	100%
Suffocation[a]	/	/	86.4	88.2	87.4
Exsanguination[b]	/	/	3.6	3.9	3.8
Poisoning[c]	/	/	4.6	3.5	4.0
Firearm	/	/	0.2	0.0	0.1
Other[d]	/	/	4.9	4.0	4.4
Location of suicide event[e]	100%	100%	100%	100%	100%
Prisoner's cell/room	78.6	79.9	74.8	75.7	75.3
Special medical/mental health services unit	/	/	5.9	4.4	5.1
Segregation unit[f]	/	/	9.4	10.8	10.2
Elsewhere within prison facility[g]	7.1	6.4	5.2	6.8	6.1
Outside of prison facility[h]	1.9	1.9	1.6	0.2	0.8
Other[i]	4.5	3.1	0.8	0.7	0.7
Prisoner had an overnight stay in a mental health facility after prison admission	/	/	100%	100%	100%
Yes	/	/	18.6	12.4	15.1
No	/	/	47.1	54.6	51.4
Unknown	/	/	30.6	32.4	31.6

Note: Includes deaths in publicly and privately operated state facilities and in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. As of December 30, 2001, sentenced felons from the District of Columbia were the responsibility of the Federal Bureau of Prisons. Details may not sum to totals due to rounding and missing data. Data may have been revised from previously published statistics. The 2001–19 category reflects 2010–19 percentages because data were first collected in 2010. See *Methodology*.

/Not collected.

[a]Includes hanging, strangulation, asphyxia, anoxia, and other methods of reducing oxygen intake.

[b]Includes all types of sharp force trauma or other injuries that cause acute loss of blood.

[c]Includes drug overdoses and ingestion or use of other poisonous substances.

[d]Includes self-inflicted blunt force trauma, dehydration, and unknown or unreported causes.

[e]Location where prisoner attempted to commit suicide. May not reflect actual location of death.

[f]Includes prisoners on death row.

[g]Includes temporary holding areas or lockups and common areas within the facility, such as prison yards, cafeterias, or kitchens.

[h]Includes community medical or mental health facilities not associated with the prison.

[i]Includes deaths that occurred while in transit to an external medical or mental health center.

Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001–19.

TABLE 16

Percent of suicides in federal prisons, by demographic characteristics of prisoners, 2015–19

Prisoner characteristic	2015–19
Total suicides	120
Sex	100%
Male	98.3
Female	1.7
Race/ethnicity	100%
White[a]	59.2
Black[a]	17.5
Hispanic	11.7
American Indian/Alaska Native[a]	9.2
Asian/Native Hawaiian/Other Pacific Islander[a]	2.5
Other[a,b]	0.0
Age	100%
24 or younger	2.5
25–34	20.0
35–44	35.8
45–54	25.8
55 or older	15.8

Note: Includes deaths in Federal Bureau of Prisons (BOP) facilities and excludes deaths in privately operated federal facilities. As of December 30, 2001, sentenced felons from the District of Columbia were the responsibility of the BOP. Details may not sum to totals due to rounding and missing data. Data may have been revised from previously published statistics. See *Methodology*.

[a]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[b]Includes persons of two or more races or other unspecified races.

Source: Bureau of Justice Statistics, Federal Law Enforcement Agency Deaths in Custody Reporting Program, 2015–19.

TABLE 17

Average rate of suicides per 100,000 prisoners in federal prisons, by demographic characteristics of prisoners, 2015–19

Prisoner characteristic	2015–19
Total	16
Sex	
Male	17
Female	4
Race/ethnicity	
White[a]	43
Black[a]	9
Hispanic	5
American Indian/Alaska Native[a]	77
Asian/Native Hawaiian/Other Pacific Islander[a]	26 !
Other[a,b]	0
Age	
24 or younger	9 !
25–34	11
35–44	16
45–54	19
55 or older	21

Note: Rates are based on the annual number of suicides and the December 31 custody population in federal prisons. Includes deaths and populations in Federal Bureau of Prisons (BOP) facilities and excludes deaths and populations in privately operated federal facilities. As of December 30, 2001, sentenced felons from the District of Columbia were the responsibility of the BOP. Data may have been revised from previously published statistics. See *Methodology*.

! Interpret with caution. Estimate is based on 10 or fewer cases.

[a]Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic whites and "black" refers to non-Hispanic blacks).

[b]Includes persons of two or more races or other unspecified races.

Source: Bureau of Justice Statistics, Federal Law Enforcement Agency Deaths in Custody Reporting Program, 2015–19; and National Prisoner Statistics program, 2015–19.

TABLE 18

Percent of suicides in federal prisons, by criminal justice characteristics of prisoners, 2015–19

Prisoner characteristic	2015–19
Total suicides	120
Most serious offense[a]	100%
Homicide/aggravated assault	10.0
Sex offense	19.2
Robbery	10.8
Drugs	13.3
Burglary/larceny	6.7
Fraud/bribery/extortion	3.3
Weapons/explosives	20.0
Immigration	3.3
Court charge	0.8
Time served in prison on current sentence	100%
1 week or less	0.8
1.1 weeks–1 month	3.3
1.1–6 months	9.2
6.1 months–1 year	7.5
1.1–5 years	33.3
5.1–10 years	18.3
10.1 years or more	12.5
Hold status	100%
Federal prison	76.7
Other authority[b]	10.8

Note: Includes deaths in Federal Bureau of Prisons (BOP) facilities and excludes deaths in privately operated federal facilities. As of December 30, 2001, sentenced felons from the District of Columbia were the responsibility of the BOP. Details may not sum to totals due to rounding and missing data. Data may have been revised from previously published statistics. See *Methodology*.

[a]For prisoners convicted of more than one crime, the most serious offense is the one that carries the longest sentence.

[b]Includes persons held for states, the U.S. military, or the District of Columbia; under treatment or hospital care; or on supervised release in a federal community corrections center.

Source: Bureau of Justice Statistics, Federal Law Enforcement Agency Deaths in Custody Reporting Program, 2015–19.

TABLE 19

Percent of suicides in federal prisons, by circumstances of death, 2015–19

Circumstance of death	2015–19
Total suicides	120
Time of death[a]	100%
Morning (6 a.m.–12 p.m.)	29.6
Afternoon (12 p.m.–6 p.m.)	18.5
Evening (6 p.m.–12 a.m.)	25.9
Overnight (12 a.m.–6 a.m.)	25.9
Method of suicide	100%
Suffocation[b]	80.8
Exsanguination[c]	5.8
Poisoning[d]	6.7
Firearm	3.3
Other[e]	3.3
Location of death[f]	100%
General housing within prison facility/on prison grounds	13.3
Segregation unit	13.3
Medical/nursing care services unit within prison facility	3.3
Medical/urgent care center outside of prison facility	57.5
Other/unspecified/unknown	12.5

Note: Includes deaths in Federal Bureau of Prisons (BOP) facilities and excludes deaths in privately operated federal facilities. As of December 30, 2001, sentenced felons from the District of Columbia were the responsibility of the BOP. Details may not sum to totals due to rounding and missing data. Data may have been revised from previously published statistics. See *Methodology*.

[a]The 2015–19 category reflects 2019 percentages because these data were collected only in 2019.

[b]Includes hanging, strangulation, asphyxia, anoxia, and other methods of reducing oxygen intake.

[c]Includes all types of sharp force trauma or other injuries that cause acute loss of blood.

[d]Includes drug overdoses and ingestion or use of other poisonous substances.

[e]Includes self-inflicted blunt force trauma, dehydration, and unknown or unreported causes.

[f]The BOP reported only the actual location of death, not where the suicide event occurred.

Source: Bureau of Justice Statistics, Federal Law Enforcement Agency Deaths in Custody Reporting Program, 2015–19.

TABLE 20

Percent of state and federal prisons, by number of suicides and facility characteristics, 2019

Facility characteristic	Number of prison facilities	Total	No suicides	1 suicide[a]	2 or more suicides
Total	1,161	1,161	944	146	71
Prison operator					
Federal	111	100%	82.9%	14.4%	2.7%
State/joint state and local	968	100%	80.6	12.7	6.7
Private	82	100%	87.8	8.5	3.7
Prison main function[b]					
General adult housing	979	100%	80.8%	12.8%	6.4%
Alcohol/drug treatment	49	100%	95.9	4.1	0.0
Reception/diagnostic	41	100%	70.7	19.5	9.8
Medical treatment	19	100%	68.4	21.1	10.5
Mental health/psychiatric treatment	21	100%	81.0	19.1	0.0
Work facility/boot camp[c]	8	100%	100	0.0	0.0
Other[d]	44	100%	88.6	6.8	4.5
Programs offered[b,e]					
Drug treatment	918	100%	80.3%	13.7%	6.0%
Alcohol treatment	915	100%	79.7	14.1	6.2
Psychiatric care	721	100%	77.1	15.5	7.4
Anger management	774	100%	78.6	14.2	7.2
Employment training	795	100%	79.0	14.3	6.7
Life skills	856	100%	79.0	14.5	6.5
Parenting skills	669	100%	81.2	13.2	5.7
Capacity[b,f]					
Prison facilities operating at 100% capacity or less	715	100%	84.1%	10.6%	5.3%
Prison facilities operating at more than 100% capacity	216	100%	76.9	16.7	6.5
Median rated/design capacity			927 beds	1,365 beds	1,738 beds
Mean rated/design capacity			1,004.9	1,598.0	1,998.4

Note: Includes state and federal confinement facilities. Excludes state and federal community corrections facilities where offenders spend 50% or more of the day outside of confinement. Includes deaths in publicly and privately operated state facilities and in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Includes deaths in Federal Bureau of Prisons (BOP) facilities and excludes deaths in privately operated federal facilities. As of December 30, 2001, sentenced felons from the District of Columbia were the responsibility of the BOP. Details may not sum to totals due to rounding and missing data. Data may have been revised from previously published statistics. See appendix table 1 for number of facilities by type and operator. See *Methodology*.

[a]Excludes three suicides reported to BJS's Mortality in Correctional Institutions collection by facilities that were not considered confinement facilities in the Census of State and Federal Correctional Facilities.

[b]As of midyear (last weekday in June).

[c]Includes facilities that primarily hold probation and parole violators, prerelease facilities, and other facilities that may allow movement in the community for less than 50% of the day.

[d]Includes housing for specific populations, such as juvenile offenders, sex offenders, or low security non-U.S. citizens; vocational and work camps; faith-based facilities; and geriatric care facilities.

[e]Prison facilities can offer multiple programs. The 2019 Census of State and Federal Correctional Facilities did not measure whether prisoners who died by suicide had participated in or had access to the programs.

[f]Facilities operating above 100% capacity held more prisoners than their rated or design capacity. A total of 275 facilities did not report either type of capacity. See *Terms and definitions*.

Source: Bureau of Justice Statistics, Census of State and Federal Correctional Facilities, 2019; Federal Law Enforcement Agency Deaths in Custody Reporting Program, 2019; and Mortality in Correctional Institutions, 2019.

TABLE 21

Percent of state and federal prisons, by number of suicides and population characteristics, 2019

Population characteristic	Number of prison facilities	Total	No suicides	1 suicide[a]	2 or more suicides
Total	1,161	1,161	944	146	71
Prisoners in facility[b]					
499 or fewer	315	100%	97.1%	2.2%	0.6%
500–999	280	100%	87.9	9.3	2.9
1,000–1,499	281	100%	79.0	15.3	5.7
1,500–1,999	137	100%	61.3	26.3	12.4
2,000–2,499	65	100%	61.5	21.5	16.9
2,500 or more	83	100%	55.4	24.1	20.5
Security level					
Maximum[c]	376	100%	64.6%	21.3%	14.1%
Medium[d]	451	100%	84.7	11.8	3.6
Minimum	289	100%	96.2	3.5	0.4
Uncategorized	47	100%	91.5	6.4	2.1
Prisoners in restricted housing[b,e]			5.5%	6.5%	11.5%
Facility staff with security responsibilities[b]			72.8%	68.0%	68.0%
Prisoners per security staff member[b,f]					
Daytime shift			16.9 prisoners	16.5 prisoners	17.2 prisoners
Nighttime shift			24.0	24.1	24.6
Overnight shift			51.4	53.8	61.9
Total security staff			4.9	4.7	4.8

Note: Includes state and federal confinement facilities. Excludes state and federal community corrections facilities where offenders spend 50% or more of the day outside of confinement. Includes deaths in publicly and privately operated state facilities and in the combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Includes deaths in Federal Bureau of Prisons (BOP) facilities and excludes deaths in privately operated federal facilities. As of December 30, 2001, sentenced felons from the District of Columbia were the responsibility of the BOP. Details may not sum to totals due to rounding and missing data. Data may have been revised from previously published statistics. See appendix table 1 for number of facilities by type and operator. See *Methodology*.

[a]Excludes three suicides reported to BJS's Mortality in Correctional Institutions collection by facilities that were not considered confinement facilities in the Census of State and Federal Correctional Facilities.

[b]As of midyear (last weekday in June).

[c]Includes super maximum facilities, administrative facilities, and facilities reporting a range of security levels with the highest level being maximum.

[d]Includes facilities that reported multilevel physical security in which the closest security level was medium.

[e]Includes prisoners held in protective custody, in administrative segregation, for disciplinary reasons, on death row, on suicide watch, or in other types of housing apart from the facility's general population. Percentages are based on the total number of prisoners in facilities with restricted housing programs.

[f]Ratios are based on prison facilities that reported staffing levels for all shifts.

Source: Bureau of Justice Statistics, Census of State and Federal Correctional Facilities, 2019; Federal Law Enforcement Agency Deaths in Custody Reporting Program, 2019; and Mortality in Correctional Institutions, 2019.

Methodology

Data sources

Mortality in Correctional Institutions, 2000-2019

The Mortality in Correctional Institutions (MCI), formerly the Deaths in Custody Reporting Program (DCRP), was an annual Bureau of Justice Statistics (BJS) data collection from 2000 to 2019. The MCI obtained national-, state-, and incident-level data on adults who died while in the physical custody of the 50 state departments of corrections (DOCs) or in the physical custody of the approximately 2,800 local jail jurisdictions with adult populations nationwide. BJS defines a jail as a locally operated correctional facility that confines persons before or after adjudication for more than 72 hours, excluding temporary lockups.

The DCRP began in 2000 in response to the Death in Custody Reporting Act of 2000 (DICRA; P.L. 106-297) and was the only national statistical collection providing comprehensive information about deaths in adult correctional facilities. Starting in 2000, BJS collected data directly from the approximately 2,800 jail jurisdictions in the U.S. and maintained an average annual response rate of 98%. The jail universe for the MCI included all jails operating at the time of data collection each year. BJS updated the jail frame annually to document jails that had closed, consolidated, or otherwise eliminated operations. The most recent jail universe identified 2,925 jurisdictions that represented 3,130 jail facilities. Of these, 2,858 jurisdictions (98%) participated in the MCI in 2019. A jail jurisdiction is a legal entity that manages jail facilities. Jail jurisdictions typically operate at the county level, and a sheriff's office or jail administrator usually manages the local facilities. MCI data identify the jail facility where an inmate died, but data are summarized at the jail jurisdiction level.

Collection of data from state DOCs began in 2001, and BJS maintained a 100% response rate over all years. Until 2015, the Federal Bureau of Prisons (BOP) submitted aggregate counts of the number of male and female deaths to BJS, by cause of death. The BOP started reporting decedent-level data to BJS in 2015, including individual demographic and criminal justice characteristics through the Federal Law Enforcement Agency Deaths in Custody Reporting Program. In 2017, BJS changed the name from the DCRP to MCI to more accurately describe the data collection.

In the MCI, custody refers to the physical holding of a person in a facility or to the period during which a correctional authority maintains a chain of custody over an inmate. For instance, if a jail transports an ill inmate to a hospital for medical services and that inmate dies in the hospital while in the chain of custody of the jail, then that death is counted as a death in custody. A death that occurs when an inmate is not in the custody of a correctional authority is considered beyond the scope of the MCI. Deaths were considered out of scope for inmates who were on escape status or under the supervision of community corrections, such as on probation, parole, or home electronic monitoring. Local jail and state correctional officials were asked to determine whether the inmate was in the physical custody of the jurisdiction at the time of death, regardless of the reason the inmate was being held. Some local jails hold state prisoners, but if a prisoner dies in the custody of the local jail, the death is attributed to the jail, not the state DOC.

Custody is further complicated by the functions of some sheriff's offices, including dual responsibilities for law enforcement and jail administration. As a result, some deaths that respondents reported as jail deaths occurred before the jail had custody of the decedent. Deaths that occurred in the process of arrest were identified by BJS and excluded by using information about the circumstances surrounding the death.

Mortality data measured by the MCI included the location and type of facility where the inmate died, decedent characteristics (sex, race or ethnicity, and age), admission date, conviction status, and admission offense. MCI respondents were instructed to report on the cause of death as determined by autopsy or another official medical investigation. For the MCI, deaths due to accidental intoxication, other accidents, suicides, and homicides were considered discrete causes of death. Although the manner and cause of death are distinct from one another, no such distinction was made in the MCI. When reporting a death due to illness, accident, suicide, intoxication, or homicide, BJS requested that respondents describe the events surrounding these deaths. Clinical data specialists converted text entries that described illness-related deaths into standard medical codes from the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10).

The MCI also collected data on the circumstances surrounding the death (the cause, time, and location of death), whether an autopsy was conducted, and the availability of autopsy results to the respondent. Specifically for suicide deaths, from 2008 to 2019, BJS asked respondents to briefly describe the event in the MCI and to report whether the decedent had spent at least one night in a mental health facility since admission to prison or jail.

BJS ceased collection of mortality data in state and local correctional facilities after the 2019 reference year. When DICRA was reauthorized in 2014 (P.L. 113-242), it included additional enforcement and reporting compliance requirements that are incompatible with BJS's authorizing statute as a federal statistical agency. The U.S Department of Justice (DOJ) determined it would be more appropriate for the Bureau of Justice Assistance (BJA) to administer the program and collect mortality data for the DOJ starting with quarter 1 of fiscal year 2019 (October to December 2019). State departments of corrections and local jails now report their death information on a quarterly basis to centralized state agencies, which compile and submit these data to BJA to comply with all applicable requirements in P.L. 113-242.

Census of Jails, 2019

BJS conducts the Census of Jails (COJ) periodically to collect jail data through a complete enumeration of local jail facilities and BOP detention facilities. The 2019 COJ was the eleventh administration since 1970. Data were collected through a web-based survey during the fall of 2019, with a reference date of June 30, 2019.

The COJ gathers data from jails holding inmates beyond arraignment, usually for a period exceeding 72 hours. Jail facilities are intended to hold adults, but some also hold juveniles (persons age 17 or younger). The universe of the COJ consists of all local jail jurisdictions (including county, city, regional, and privately operated jail facilities) and BOP detention facilities that function as jails.[1] The COJ universe excludes separate temporary holding facilities (such as drunk tanks and police lockups) that do not hold persons after they have been formally charged in court. However, temporary holding facilities that are operated as part of a local jail are included. The combined jail and prison systems in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont are excluded from the COJ, as they are operated by state DOCs, and included in BJS's Census of State and Federal Correctional Facilities.

The COJ uses two data collection forms for multiple-facility jail jurisdictions. The CJ-3A obtains information on the count, race or ethnicity, conviction status, citizenship, holding agency, and average daily population (ADP) for jurisdictions that have multiple facilities under a single legal authority and have one or more reporting units. The jurisdictions also submit one CJ-3A Addendum form for each facility under their legal authority. The CJ-3A Addendum requests information on the purposes and functions of each jail, the rated capacity, and the existence of any consent decrees placed on the facilities. Single-facility jurisdictions received a CJ-3 form in the 2019 COJ, which combined the questions from the CJ-3A and CJ-3A Addendum forms.

MCI data on suicides that occurred in 2019 were linked to the 2019 COJ at both the jurisdiction and facility levels. Jurisdiction matching was based on the common jurisdiction identification number that BJS uses in jail collections. One suicide reported to the MCI occurred in a single-facility jurisdiction that did not respond to the 2019 COJ. This suicide was excluded from analyses of the linked collections at both the jurisdiction and facility levels.

COJ facility-level data were linked to MCI suicides from 2019 using the facility name, city, and state. Two jurisdictions reported suicides to the MCI but did not indicate the facilities or cities where they occurred. These deaths were excluded from the analysis of linked COJ-MCI data at the facility level. Additionally, a medical facility outside of the jail was reported as the location of death for multiple suicides in 2019. When these occurred in single-jail jurisdictions, BJS could attribute the suicide to their jail facility. However, five multiple-jail jurisdictions had suicides whose locations of death were community medical facilities not associated with the jails. Because these suicides could not be attributed to any particular jail, they were excluded from the facility-level analysis of the linked COJ-MCI data.

Because the 2019 COJ represents a complete enumeration of local jails in the U.S., the results are not subject to sampling error. However, the results were affected by unit and item nonresponse, and adjustments were made to account for nonresponse.

[1]Regional jail jurisdictions are created by two or more local governing bodies through cooperative agreements.

The 2019 COJ had a response rate of 94%. Seventy-four jail jurisdictions did not respond to the census. To reduce nonresponse bias, nonresponse weighting was implemented. To calculate the nonresponse weight, missing data were first imputed for two variables (confined inmate population and the number of juveniles), using a carry-forward cold-deck procedure. The missing data were replaced with the most recent prior-year data that the same jail jurisdictions reported to the 2016, 2017, or 2018 Annual Survey of Jails (ASJ) or the MCI Annual Summary File. For cases with no prior-year data, a weighted sequential hot-deck procedure was implemented to impute missing data, where the donor for each missing item was randomly selected from a set of similar jails, sorted by related auxiliary population values (e.g., jail size, inmate sex distribution, state or region, and county classification). Next, all jail jurisdictions were classified into 10 strata based on their reported or imputed values of confined population, the presence of juveniles, and whether they were operated as a regional jail in the 2019 COJ. The nonresponse weight was calculated as the total confined population of all active jail jurisdictions in each state and stratum, divided by the sum of the confined population of all jail jurisdictions in each state and stratum that responded to the 2019 COJ—

$$w_{sh} = \frac{\sum_{i=1}^{n_{sh}} p_{shi} \times A_{shi}}{\sum_{i=1}^{n_h} p_{shi} \times R_{shi}}$$

where—

n_{sh} = number of jail jurisdictions in state s and stratum h,

p_{shi} = confined population for jail jurisdiction i in state s and stratum h,

A_{shi} = active status indicator for jurisdiction i in state s and stratum h (1 = active, 0 = out of scope), and

R_{shi} = response indicator of jurisdiction i in state s and stratum h (1 = respondent, 0 = nonrespondent).

Census of State and Federal Correctional Facilities, 2019

BJS conducted the Census of State and Federal Correctional Facilities (CCF) between September 2019 and March 2020, with a reference date of June 30, 2019. Based on the primary function of the facility and the percentage of prisoners who were allowed to leave the facility unaccompanied for work or study release, BJS classified prisons as confinement or community corrections facilities. Of the 1,982 prison facilities in the original universe for CCF, 282 were deemed ineligible, and 23 did not respond to the survey. This resulted in an overall response rate of 98.6%. In linking CCF data to MCI suicide records, BJS included only the confinement prisons because these aligned with the MCI definition of in-custody deaths. This resulted in a file of 1,189 confinement facilities, of which 220 had at least one suicide. Because of the high response rate, CCF data were not weighted. BJS combined state and federal facilities in the analysis for tables 20 and 21 because disaggregation of the smaller number of federal facilities by count of suicides and other characteristics could allow for the identification of individuals.

National Prisoner Statistics program, 2001-2019

Data on state and federal prison populations used as denominators for mortality rates were obtained from BJS's National Prisoner Statistics (NPS) program, which collects information from state DOCs and the BOP on custody and jurisdiction populations, admissions to and releases from prison, the capacity of state and federal prison systems, and some demographic characteristics of prisoners. BJS used the NPS and individual-level data from the National Corrections Reporting Program (NCRP) and the Federal Justice Statistics Program (FJSP) to obtain the age distribution of the prison population.

The original DICRA legislation did not require federal law enforcement or correctional authorities to report deaths in prisons. However, from 2001 to 2014, the BOP reported aggregate counts of deaths in BOP-operated facilities to the NPS. Then in 2015, the reauthorized DICRA legislation made federal reporting of deaths a requirement, and the BOP began providing individual-level death records to BJS from both BOP- and privately operated federal facilities as part of the Federal Law Enforcement Agency Deaths in Custody Reporting Program. In the current analysis of suicides, BJS excluded deaths in private federal prisons from 2015 to 2019 to allow for comparability over time. Table 1 in this report shows total deaths from all causes, as well as the number of suicides per year in BOP-operated facilities. A total of nine deaths in private federal prisons in 2015, seven in 2016, seven in 2017, five in 2018, and seven in 2019 were excluded.

Among these deaths, one suicide in 2015, one in 2016, and none in 2017, 2018, and 2019.

Federal Justice Statistics Program

The federal prison data from BJS's FJSP are an annual collection of administrative records for each prisoner who was in custody on December 31. BJS obtains these records from the BOP. Data elements include demographic, criminal justice, and sentencing characteristics. For this report, BJS used the age distributions obtained from the FJSP annual prison files as denominators for suicide rates by age in the BOP.

National Corrections Reporting Program

Similar to FJSP, the NCRP obtains individual-level administrative records for all persons in the custody of state- or privately operated prison facilities at year-end. BJS obtained annual age distributions for state prisoners from the NCRP and used them to calculate suicide rates by age for this report.

Reported statistics

Mortality data in this report include the number of deaths by suicide, suicide rates by year, the cause of death, selected decedent and suicide event characteristics, the state where the death occurred, and characteristics of facilities that experienced one or more suicides in 2019. The data are separated by type of facility (local jail, state DOC, or BOP). The jail and prison populations differ substantially from the U.S. resident population in terms of age, race or ethnicity, and sex distributions. These differences preclude direct comparison of suicide rates between incarcerated populations and the U.S. resident population.

Suicide mortality rates are calculated per 100,000 local jail inmates and per 100,000 state or federal prisoners, with the denominators providing estimates of the number of person-years of exposure in custody in institutional corrections (*person-years* combines time in a correctional institution with the number of inmates to measure actual exposure to a correctional institution setting).

The mortality rate for local jails is calculated as the number of deaths per year divided by the average daily population (ADP), with the resulting quotient multiplied by 100,000. The ADP for jails is defined as the average daily number of inmates held in a jail jurisdiction during a calendar year, from January 1 through December 31. The ADP is used as the denominator for mortality rates to accommodate the high turnover and daily fluctuation in local jail populations. Compared to a single-day inmate count, the ADP is a better indicator of the number of days per year that an inmate is exposed to the risk of death. Jail populations have a much higher turnover than prison populations. Mean length of stay is about 26 days in local jails, compared to 2 years in state prisons. The ADP reflects the annual number of admissions and mean length of stay, and it can be expressed as the product of these two values. When mean length of stay is expressed in years, the ADP is equivalent to the number of person-years spent by inmates during a given year.

ADP data are received directly from jails through the MCI using the CJ-9A summary form. Starting in 2002, BJS collected the ADP directly from respondents. Prior to 2002, the ADP was calculated by taking the average of the January 1 count from the prior year and the December 31 count from the reference year.

The mortality rate for state or federal prisoners is calculated as the number of deaths per year divided by the December 31 population of state or federal prisoners in custody, with the resulting quotient multiplied by 100,000. The population of state prisoners used in rate calculations includes prisoners held in privately operated facilities, while the population in federal prisons does not. To improve comparability between years, this report includes mortality rates of state prisons that were reestimated for prior years using updated year-end custody populations, including privately operated facilities.

Estimating population characteristics of inmates to calculate mortality rates by demographic subgroups

Data from several data collections were used to generate distributions of sex, race or ethnicity, and age among inmates in local jails and to estimate how these demographic characteristics were distributed by ADP. These collections were chosen because they were conducted closest in time to the 2019 reference year. They include two types of data: (1) in-person survey data, where jail inmates are asked directly to identify their date of birth, sex at birth, race, and ethnicity and (2) administrative data, which is derived from the official operational records maintained by the jail facility and may differ from how an inmate

would self-identify (especially in terms of race and ethnicity) if given the chance. BJS's administrative data collections on jails include—

- the MCI, conducted annually
- the ASJ, conducted annually
- the COJ, conducted every 5 to 6 years, including in 2013 and 2019.

BJS's in-person inmate survey data on jails include—

- the Survey of Inmates in Local Jails (SILJ), last conducted in 2002
- the National Inmate Survey (NIS), conducted in 2006, 2007 to 2009, and 2012.

Prior to 2010, the ASJ provided estimates of local jail inmates by sex for each year of the MCI collection. The ASJ percentages were applied to each year's ADP from the MCI to estimate the ADP of male and female inmates. Starting in 2010, sex-specific data on ADP from the MCI were used to calculate the denominators for mortality rates for males and females. Data from the SILJ, NIS, and COJ were used to estimate the relative distribution of adults by race or ethnicity for different periods. Because the SILJ (2002), NIS (2007 to 2009), and COJ (2013) are not fielded annually, the population estimates were smoothed before being applied to MCI data for specific time periods. The SILJ estimates were used to cover the period from 2000 to 2004, the NIS estimates to cover years 2005 to 2012, and the COJ estimates to cover years 2013 to 2019. In all cases, the percentages associated with the distribution of race or ethnicity were applied to the ADP.

To estimate the distribution of local jail inmates by age, BJS first obtained an estimate of the number of inmates age 17 or younger from the ASJ (2000 to 2012 and 2014 to 2016) and the 2013 COJ. An estimate of the ADP of inmates age 17 or younger was obtained by applying the annual percentage of inmates age 17 or younger from the ASJ and COJ to the annual ADP collected in the MCI. To estimate the distribution of adult inmates by age, data from the 2002 SILJ were used to estimate the relative distribution of adults by age for the years 2000 to 2006, and data from the NIS collections were used for years 2007 to 2016. Estimates were directly available from these sources for 2002, 2007, 2009, and 2012. The age distribution for 2002 (SILJ) was applied to MCI data for 2000 and 2001, and the distribution from 2012 (NIS) was used for 2013 to 2018. Estimates were smoothed to account for gaps in reference years when age estimates were not available (2003 to 2006, 2008, 2010, and 2011).

Age and sex distributions of the state and federal prison populations were estimated using the NPS, NCRP, and FJSP data collections. Rates for race or ethnicity were also derived from these collections. They have been updated from previous years and may not match previously reported rates. Race or ethnicity reported in the NPS, NCRP, and FJSP come from administrative records of prisoners and may not reflect self-reporting by prisoners. Distributions of race or ethnicity were adjusted based on self-reported data collected from interviews with prisoners through BJS's national prisoner surveys. Previously, distributions of race or ethnicity were derived from BJS's 2004 Survey of Inmates in State and Federal Correctional Facilities. In 2017, BJS updated estimates of prisoners' race or ethnicity using new data from the 2016 Survey of Prison Inmates (formerly the Survey of Inmates in State and Federal Correctional Facilities). Annual distributions of race or ethnicity were weighted by the number of years from the most recent prisoner survey (2004 or 2016). For complete details on the methodology used to estimate distributions of race or ethnicity, see *Prisoners in 2016* (NCJ 251149, BJS, January 2018).

Interpreting rates among small populations

MCI data on deaths in local jails are not subject to sampling error because the data represent a full enumeration of deaths. However, according to Brillinger and NCHS, mortality data from a complete enumeration may be subject to random error because "the number of deaths that actually occurred may be considered as one of a large series of possible results that could have arisen under the same set of circumstances."[2,3] The random variation can be large when the number of deaths is small. Therefore, caution is warranted when interpreting statistics that are based on small numbers of deaths.

Using the NCHS and Brillinger methods, BJS quantified random variation by assuming that the

[2]See Brillinger, D. R. (1986). The natural variability of vital rates and associated statistics. *Biometrics, 42*(4), 693-734.

[3]See Xu, J., Kochanek, K. D., Murphy, S. L., & Tejada-Vera, B. (2010). *Deaths: Final data for 2007* (National Vital Statistics Reports, Vol. 58, No. 19). National Center for Health Statistics. https://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_19.pdf

appropriate underlying probability distribution for the number of deaths was a Poisson distribution. This provided a simple and reasonable approach for estimating variances in mortality statistics when the probability of dying is low. Variances were calculated based on the assumption of a Poisson process. From these variances, estimates of relative random error were calculated. These estimates are comparable to the relative standard error because the relative random error is the ratio of random error derived from the Poisson variance to the number of deaths. Following NCHS practice, when the relative random error exceeded 30%, estimated mortality rates were flagged with an "!" symbol to show the instability of the rate. (i.e., Interpret with caution. Estimate is based on 10 or fewer cases.)

APPENDIX TABLE 1

Number of correctional facilities, by type and operator, 2019

Operator	All facilities*	Confinement	Community-based
Total	1,677	1,161	516
Public	1,266	1,079	187
Federal	111	111	0
State	1,155	968	187
Private	411	82	329

*There were 139 additional facilities linked to another facility for which data could not be reported separately. Data from these facilities were merged with data for 96 facilities.

Source: Bureau of Justice Statistics, Census of State and Federal Adult Correctional Facilities, 2019.

The Bureau of Justice Statistics of the U.S. Department of Justice is the principal federal agency responsible for measuring crime, criminal victimization, criminal offenders, victims of crime, correlates of crime, and the operation of criminal and civil justice systems at the federal, state, tribal, and local levels. BJS collects, analyzes, and disseminates reliable statistics on crime and justice systems in the United States, supports improvements to state and local criminal justice information systems, and participates with national and international organizations to develop and recommend national standards for justice statistics. Doris J. James is the acting director.

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EXHIBIT D

January 4, 2021 and December 31, 2021 LA Jail Population Numbers
Source: *Vera Institute for Justice, Care First L.A.: Tracking Jail Decarceration*
(Tab: Population Changes, Population Over Time)
https://www.vera.org/care-first-la-tracking-jail-decarceration
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