WORLD PEACE FOUNDATION

OCCASIONAL PAPER #24 | August 26, 2020

96 DEATHS IN DETENTION:

A VIEW OF COVID-19 IN THE FEDERAL BUREAU OF PRISONS AS CAPTURED IN DEATH NOTICES

BY BRIDGET CONLEY AND MATTHEW SIEGEL[1]

The **World Peace Foundation**, an operating foundation affiliated solely with the Fletcher School at Tufts University, aims to provide intellectual leadership on issues of peace, justice and security. We believe that innovative research and teaching are critical to the challenges of making peace around the world, and should go hand-in-hand with advocacy and practical engagement with the toughest issues. To respond to organized violence today, we not only need new instruments and tools—we need a new vision of peace. Our challenge is to reinvent peace.

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INTRODUCTION

Between March 28 and July 31, 2020, 96 people died while incarcerated by the Federal Bureau of Prisons (BOP) due to COVID-19 related causes. Each death was announced by the BOP in a press release that provided stark details about the person and key dates in the progression of the virus. Analysis of all 96 death notices reveals patterns whereby extremely sick people rarely received medical attention before their symptoms overwhelmed them. The notices, published by the BOP, help confirm the picture previously told by incarcerated people and their advocates, lawyers that represent them, and journalists of inadequate medical attention, testing, and epidemic response in prisons run by the United States government.

Part One provides background on the epidemic in American prisons, with focus on the BOP facilities. Part Two presents analysis of the 96 death notices, discussing trends and anomalous cases. Adding detail from outside the perspective of the BOP, Part Three turns to stories of people who died as covered in media accounts to illustrate concerns that have been raised about BOP's handling of the epidemic. Part Four concludes.

1 We would to thank Alex de Waal, Amaia Elorza Arregi, and Jim Carey for their review of earlier drafts of this paper; the UCLA Law Covid-19 Behind Bars Data Project; and the Tufts University Prison Initiative at Tisch College. All mistakes are our own.

This paper is part of the WPF program on COVID-19 in American prisons, Detentionville. It reflects our concern that the possibilities for advancing peace globally are tied to the protection of the most vulnerable civilian populations. While our previous work has focused on threats of systematic violence against civilians, often in the context of armed conflict or political repression, the Detentionville project asserts that protection must be conceptualized as a globally integrated practice, whereby domestic and foreign policy exist along a continuum. In the context of American mass incarceration, long-standing, systemic injustices that devalue the lives of the disproportionately incarcerated Black and poor people, have now combined with an acute threat to their lives and health: COVID-19.

I. BACKGROUND: OVERVIEW OF COVID-19 IN THE FEDERAL BUREAU OF PRISONS (BOP)

Across the country and around the world, places of detention have been hotbeds for the spread of COVID-19. In the U.S., places of detention—jails, prisons, and other detention centers—exist under a web of different authorities: local sheriffs, state agencies, and the federal government. At the federal level, this includes the U.S. Marshals Services, Immigration and Customs Enforcement and, the focus of this paper, the Bureau of Prisons (BOP). The BOP falls under the U.S. Department of Justice and manages 122 prisons housing just under 160,000 people (July 31, 2020); they contract with private corporations who manage an additional 12 prisons; and the Bureau oversees both their own and privately-run Residential Re-entry Centers (RRC).

Long before COVID-19, federal prison facilities faced shortages in medical staffing and correctional officers, and overcrowding at several facilities. When the COVID-19 epidemic broke out in the U.S., the population of people detained by the BOP, along with the total 2.1 million people held in places of detention (most, 1.2 million, are held in state prisons[2]) across the country, faced an acute crisis. Incarcerated people are at increased risk for several reasons:[3] group housing inhibited the possibility for social distancing,[4] incarcerated people on average have higher rates of chronic and mental disease than the general public,[5] inadequate availability of personal protection equipment,[6] the restrictions that inhibit people's ability to undertake other behaviors for self-protection, and institutional biases that fail to prioritize incarcerated peoples' well-being.[7]

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2 Prison Policy Initiative, "Mass Incarceration: The Whole Pie," March 24, 2020 Available at: https://www.prisonpolicy.org/reports/pie2020.html. Accessed August 1, 2020.

3 The CDC referenced many of these challenges in its "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities" (version updated July 22, 2020). Available at: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html. Accessed August 1, 2020.

4 Kajstura, Aleks and Jenny Landon, April 3, 2020, "Since you asked: Is social distancing possible behind bars?" Prison Policy Initiative. Available at: https://www.prisonpolicy.org/blog/2020/04/03/density/. Accessed: August 19, 2020; and Hawks, Laura, Steffie Woolhandler; and Danny McCormick, April 28, 2020, "COVID-19 in Prisons and Jails in the United States" JAMA Intern Med. 2020;180(8):1041-1042. doi:10.1001/jamainternmed.2020.1856

5 PBai, Jennifer R., Montina Befus, Dhritiman Mukherjee, Franklin Lowy, and Elaine Larson. 2015. "Prevalence and Predictors of Chronic Health Conditions of Inmates Newly Admitted to Maximum Security Prisons" Journal of Correctional Health Care 21:3, 255 – 264; Gottfried, Emily and Sheresa Christopher. 2017. 'Mental Disorders Among Criminal Offenders: A Review of the Literature,' Journal of Correctional Health Care 23:3, 336-346.

6 See, for instance, a formal grievance dated April 16, 2020, that was filed by correctional officers that details many of the issues noted above, including the lack of PPE provided to staff. Available at: https://cdn.govexec.com/media/gbc/docs/pdfs_edit/042020cb1.pdf.

7 See a January 2, 2019 memo from the Independent Investigations and Employee Discipline at the Bureau of Prisons to Chairman Russell of the House Committee on Oversight and Reform, Subcommittee on National Security, detailing misconduct and retaliation, concluding that "senior leadership misconduct appears to be largely tolerated or ignored altogether."

The first time the BOP reported that an incarcerated person tested positive for COVID-19 within one of their facilities was on March 21st: a single person at MDC Brooklyn.[8] Over the following 132 days, through to July 31st, BOP facilities would be home to an explosion of positive cases. In total, by BOP's reporting, over 10,000 incarcerated people had tested positive, or 7% of the total population. Behind this number were concentrated outbreaks at a few hard-hit facilities, where much of the testing was concentrated.

To some extent, the number of deaths in a facility is related to the demographics and medical profile of the people incarcerated there. The profile of susceptibility to COVID-19 infection, and outcomes in terms of morbidity and mortality, in a population varies with a number of health and demographic factors including age, sex, body mass index and pre-existing health conditions. Different incarcerated populations have different susceptibility profiles, so we would not expect a straightforward correlation between cases of infection and numbers of deaths. Because of this, the list of deadliest facilities is not exactly the same as the facilities with the greatest number of people testing positive (see Table 1.1). Nonetheless, there is significant cross-over between these lists.

Table 1.1 Testing and Deaths in hard-hit BOP prisons (July 31, 2020).

Facility	State	Population	Total tested	Pending	Positive	% Pop. Tested	% of Pop. Positive	Test Positivity	Deaths
Lompoc FCI	CA	1089	1068	0	833	98%	76%	78%	2
Seagoville FCI	TX	1760	1667	5	1319	95%	75%	79%	3
Terminal Island FCI	CA	941	931	2	643	99%	68%	69%	10
Butner Low FCI	NC	1101	1092	0	621	99%	56%	57%	16
Elkton FCI	OH	2196	2178	0	995	99%	45%	46%	9
Fort Worth FMC	TX	1328	858	9	587	65%	44%	68%	12
Carswell FMC (female)	TX	1351	1263	99	538	93%	40%	43%	3
Forrest City Low FCI	AR	1866	1682	3	669	90%	36%	40%	none
Butner Medium I FCI	NC	802	316	2	216	39%	27%	68%	9
Beaumont Low FCI	TX	1880	786	0	476	42%	25%	61%	none
Chicago MCC	IL	578	567	2	127	98%	22%	22%	none
Oakdale I FCI	LA	898	896	0	181	100%	20%	20%	7
Jesup FCI	GA	1341	370	8	256	28%	19%	69%	1
Lexington FMC	KY	1294	942	3	227	73%	18%	24%	8
Victorville Med. I FCI	CA	1077	491	353	148	46%	14%	30%	none
Danbury FCI	CT	810	806	0	90	100%	11%	11%	1
Fairton FCI	NJ	978	964	3	103	99%	11%	11%	none
Lompoc USP	CA	1310	738	96	140	56%	11%	19%	2

Data: BOP July 31, 2020. Chart: World Peace Foundation 2020.

***Note:** Red >50%; orange indicates 20 – 49%; and yellow indicates 10 – 20%. Deaths also occurred at prisons that did not comparatively large outbreaks, including: FCI Milan (3), FMC Devens (2), FCI Yazoo City (2), FCI Yazoo City (2) ,FDC Miami (1), FTC Oklahoma (1), USP Terre Haute (1) and USP Yazoo City (1).*

Not only were prisons hit hard, but so were smaller residential re-entry centers, commonly called halfway houses, some of which are managed by private companies and others directly by the BOP. While the numbers at these facilities do not compare with the hundreds or more at prisons, the rates of positive tests indicate that only people who are presumed to be positive are tested, which means as late as the end of July, the centers were not catching asymptomatic cases that can also spread the virus. For context, the WHO recommends a positive test rate of under 5% for countries in order for them to consider the virus under control.[9] During the height of the epidemic in New York City, the positive test rate was 31%, a statistic cited as demonstrating that the virus was not contained.[10] As seen in Tables 1.1 and 1.2, the positive test rate at many of these facilities is far greater than that, suggesting that the scope of the epidemic in those facilities is not fully understood.

Available at: https://republicans-oversight.house.gov/wp-content/uploads/2019/01/Memo-to-Chairman-Russell-re-BOP.pdf

8 See Appendix I for an overview of BOP abbreviations.

9 As noted by the Johns Hopkins Coronavirus Resource Center, available at: https://coronavirus.jhu.edu/testing/testing-positivity Accessed: August 19, 2020.

10 Kim, Elizabeth. April 28, 2020, "Those tested in New York City were Positive for COVID-19." Available at: https://gothamist.com/news/coronavirus-updates-april-28 (Accessed: August 19, 2020.

Table 1.2 Testing in sample Federal Residential Re-Entry Centers (July 31, 2020)

Facility	State	Total Pop.	Total tested	Pending	Positive	%Pop. tested	%Pop. positive	Rate of Test Positivity
Geo Re-Entry Inc.	NV	75	61	0	61	81%	81%	100%
GeoCare (RRC)	CA	30	16	0	16	53%	53%	100%
Dismas Charities Albuquerque (RRC)*	NM	117	60	8	60	51%	51%	100%
Hampshire House (RRC)	NH	45	20	0	20	44%	44%	100%
Dismas Corpus Christi (RRC)	TX	40	14	0	14	35%	35%	100%
Jacksonville (RRC)	FL	64	23	0	22	36%	34%	96%
Volunteers of America Dallas (RRC)*	TX	160	52	7	52	33%	33%	100%
Crosspoint San Antonio (RRC)*	TX	100	32	1	32	32%	32%	100%
Alpha House (RRC)	MO	50	6	0	6	12%	12%	100%

Data: BOP July 31, 2020. Chart: World Peace Foundation 2020.

***Notes:** *At these locations, the numbers tested, pending results and positive do not add up, and may indicate positives test results from testing outside the facility (possibly at a hospital, but the discrepancies are not explained by the BOP). ** The population for Residential Re-Entry facilities is a total bed count. The sites did not provide data on what percentage of beds were in use at the time.*

A key challenge for understanding how COVID-19 impacted populations held in BOP facilities, was the limited amount of information that the federal bureau released. At first, the BOP only reported active positive cases (as people recovered or died, the number was reduced). Until May 7th, there was no reporting at all regarding privately-managed facilities, which were home to around 15,000 people.[11] Also, on May 7th, the BOP included reporting on people who were currently positive, in addition to those who had recovered or died. Information about testing was added near the end of June.[12]

Throughout this period, troubling reports emerged from incarcerated people, lawyers representing clients,[13] advocacy groups,[14] journalists,[15] corrections officers and their unions,[16] independent monitors ordered by courts to inspect facilities,[17] and Congressional leaders exercising their oversight role.[18] Among the issues raised were the

11 Neff, Joseph, May 8, 2020, "Why did it take the Feds weeks to report Covid-19 cases in privately run prisons?" The Marshall Project. Available at https://www.themarshallproject.org/2020/05/08/why-did-it-take-the-feds-weeks-to-report-covid-19-cases-in-privately-run-prisons (Accessed: August 19, 2020.

12 The best source for tracking BOP data over time is the UCLA Law Data Behind Bars Project, available at: https://law.ucla.edu/academics/centers/criminal-justice-program/ucla-covid-19-behind-bars-data-project. Accessed: August 19, 2020.

13 See, for example, a letter from the Co-Chairs of the Federal Defender Legislative Committee on May 11, 2020, to Congressional leaders detailing the need for BOP to enact bail reform, provide broader tools for early and compassionate release and home confinement, and increased testing for incarcerated people and staff. Available at: https://www.fd.org/sites/default/files/cja_resources/2020.05.11_letter_from_fd_to_congress.pdf Accessed August 19, 2020.

14 As example, see the work of Families Against Mandatory Minimums, Available at: https://famm.org/ Accessed August 19, 2020.

15 See, for example, Pavlo, Walter, "As Bureau of Prisons Enters 'Phase 9' Of COVID-19 Plan, BOP Staff Wonder If There Is A Real Plan,"Forbes Magazine, August 7, 2020. Available at: https://www.forbes.com/sites/walterpavlo/2020/08/07/as-bureau-of-prisons-enters-phase-9-of-covid-19-plan-bop-staff-wonder-if-there-is-a-real-plan/#4a9dec29326f Accessed August 19, 2020.

16 AFGE, "A BOP Officer Contracted Coronavirus. He was told to return to work ASAP," May 4, 2020. Available at: https://www.afge.org/article/a-bop-officer-contracted-coronavirus.-he-was-told-to-return-to-work-asap/. Accessed August 19, 2020.

17 "Facility Evaluation: Metropolitan Detention Center Covid-19 Response," Dr. Homer Venters, April 30, 2020. No. 20, Civ. 01590. Available at: https://assets.documentcloud.org/documents/6880808/Dr-Homer-Venters-Report-From-Tour-of-MDC-Federal.pdf Accessed August 19, 2020.

18 Bipartisan letter from 14 U.S. Senators to William Barr and Michael Carvajal, March 23, 2020. Available at:

gross inadequacy of personal protective equipment, both the quantity and quality of supplies provided; continued transfers of people between facilities; inadequate testing of both incarcerated people and staff; forcing staff to work even while displaying symptoms of the virus; ignored medical requests; confusing information about policies related to home confinement, early and compassionate release; and negligence regarding the housing and cleanliness conditions required to protect against the virus. Stories trickled out from facilities across the country.

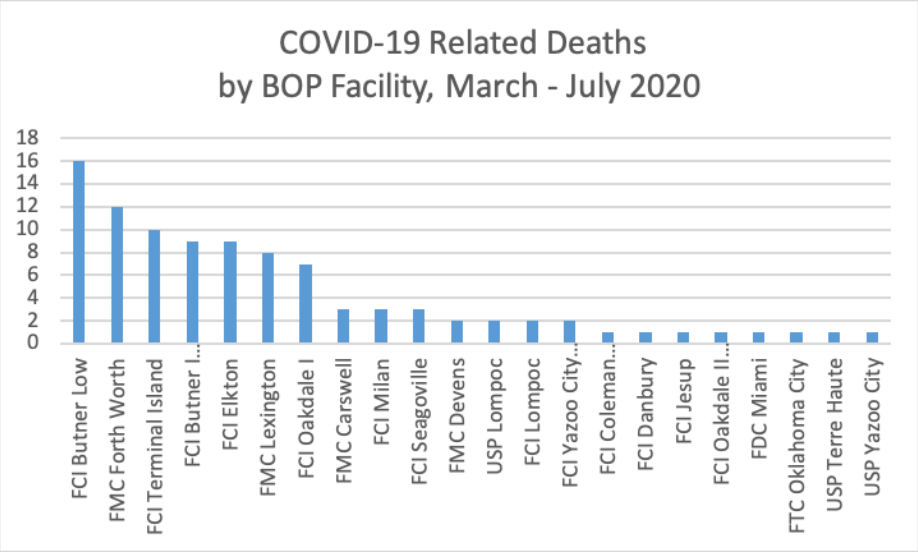
One previously untapped source of information about conditions behind the walls were press releases published by the BOP for each of the 96 people who died while incarcerated in prisons (this excludes those who died in private facilities contracted with the BOP, and all RRCs). Analyzing all 96 of these death notices, we were able to document patterns in treatment for those who would eventually perish from conditions related to COVID-19.

II. DEATH NOTICES: 'FOR IMMEDIATE RELEASE: INMATE DEATH AT…'

On March 28th, the BOP reported the first death of someone in their custody: Patrick Jones, a 49-year old man held at Oakdale FCI in Louisiana, who had "complained of a persistent cough." In the press release announcing Jones's death, the BOP noted that he was evaluated by their staff on March 19th and then transported to the local hospital where he tested positive. He was put on a ventilator on March 20th, and died eight days later.

Between March 28 and July 31,2020, there were 96 COVID-19 related deaths in 22 prisons managed by the BOP.

Graph 2.1 COVID -19 Related Deaths in BOP Custody, by Facility



Data: BOP; Graph: World Peace Foundation, 2020.

Each death was announced in a press release, most of which included two paragraphs about the person who died. These details included where the person was incarcerated, their name, and age. Additionally, the notices provided an official, stark accounting of the events that led up to their death.

https://www.durbin.senate.gov/imo/media/doc/Letter.%20to%20DOJ%20and%20BOP%20on%20COVID-19%20and%20FSA%20provisions%20-%20final%20bipartisan%20text%20with%20signature%20blocks.pdf Accessed August 19, 2020. See also video and other materials from the June 2, 2020 Hearing on Examining Best Practices for Incarceration and Detention During COVID-19, before the Senate Committee on the Judiciary. Available at: https://www.judiciary.senate.gov/meetings/examining-best-practices-for-incarceration-and-detention-during-covid-19 Accessed August 19, 2020.

Ninety-two percent of the notices also stated that those who died suffered from "long-term, pre-existing medical conditions, which the CDC lists as risk factors for developing more severe COVID-19 disease." In the case of Margarito Garcia-Fragosa, who died on April 2nd, the BOP said he had a pre-existing condition. However, his daughter denies this, saying that "He was so physically fit and healthy and when I read that, what a defamation of character."[19] In others, family members reported shock that their incarcerated loved ones with substantiated health vulnerabilities were not better protected from a life-threatening virus. The claim that those who died had pre-existing conditions appears to function as an absolution of responsibility for the deaths, but simultaneously raises the question of why people with long-term, pre-existing conditions would not have been granted a form of compassionate release or home confinement.

The second paragraph described the crimes that the person was convicted of and their sentence.

Important information was missing, including some demographic information like the person's race and ethnicity, for instance, although this information could be found by searching their name in BOP's "inmate database." The notices also do not include relevant information like whether the person had submitted medical requests or had filed for early release or home confinement. And it is also important to note that these notices are not in any way obituaries: they say nothing about the person who died.

Below, we present the findings of our analysis of the 96 death notices, including demographic information, insights on disease progression, and changes over time. We also discuss a few anomalous cases.

Demographics

Among those who died, men over age 50 are over-represented, with a significant share of the dead being over age 65. Only three women were reported to have died of COVID-19 related causes, they were aged 30, 59 and 61.

Table 2.1 BOP COVID-19-related Deaths, Age Range Breakdown

Age Range	Within total BOP population	# COVID-19 related deaths	As % of COVID-19 related deaths
31- 35	16.30%	1	1.04%
36 - 40	18.00%	1	1.04%
41 - 45	15.70%	4	4.17%
46-50	11.90%	5	5.21%
51 - 55	8.10%	11	11.46%
56 - 60	5.70%	20	20.83%
61-65	3.30%	15	15.63%
>65	2.80%	39	40.63%

Data: BOP2020 and WPF, Table WPF.

The BOP has not reported racial data for COVID-19 data it releases. However, this data was locatable based on information in the death notices. Table 2.2 provides the racial breakdown of those who have died due to COVID-19 in BOP custody, compared with racial breakdown of the entire BOP population.

19 Brown, Marcia, "When incarceration becomes a death sentence," April 9, 2020, The Progressive. Available at: https://progressive.org/dispatches/incarceration-becomes-death-sentence-brown-200409/ Accessed August 19, 2020.

Table 2.2 BOP COVID-19-related Deaths, Racial Breakdown

Race	As % of total BOP pop.	Number of deaths	As % of deaths
Asian	1.50%	3	3%
Black	38.20%	19	20%
Native American	2.30%	3	3%
White	57.90%	70	73%
TOTALS:	**99.90%**	**95**	**99%**

Data: BOP2020 and WPF, Table WPF. ***Note****: We were unable to locate data for one person.*

Disease progression

Perhaps most interestingly, the death notices provided a glimpse of the care provided and not provided to sick incarcerated people. Because every death notice presented information about the progression of the person's illness, we were able to code the progression of the symptoms as relates to the BOP's response. We note, what is presented is not a clinical analysis. Rather, the information in the death notices should be understood as narrative accounts of how the BOP tracked its response to the medical conditions of the people within its facilities. What we found was consistent evidence of serious delays in identifying sick people, isolating them from others, and providing them with prompt and adequate healthcare. Based on what we know about symptoms and disease progression, peeople incarcerated by the BOP who eventually died were likely to have displayed symptoms for 5 to 7 days before the date BOP reported as the first registry of their illness.

The progression includes: when BOP staff first recorded a sick person's symptoms, if the sick person was placed in isolation, when the person's condition declined (a broad term that was usually respiratory failure or acute respiratory distress syndrome (ARDS) but sometimes simply described as "declined" or low oxygen level), when they were transported to a local hospital, when and where they tested positive, when the person was placed on a ventilator, and the date the person died. Not every notice contained every point of progression. When dates were not specifically given, that information was left blank. The first day that BOP reported symptoms were coded as Day 0. We then counted the days that days passed between major events in the progression (which do not always follow the above order).

An example of how we coded the notices is the one issued for Gary Edward Nixon, a 57-year-old black man who was incarcerated at FCI Butner I. The BOP first reported symptoms (Day 0) when Nixon experienced respiratory failure at the prison; it was also coded as the day his condition declined (Day 0). He was transported to the hospital the same day (Day 0), where he was placed on a ventilator four days later (Day 4). The notice did not specify when or if he was placed in isolation, and only noted that while he was in the hospital, he tested positive. Those columns were left blank. He died 6 days later on April 12th (Day 6).

Table 2.3 Number of Cases that Described Each Aspect of Disease Progression.

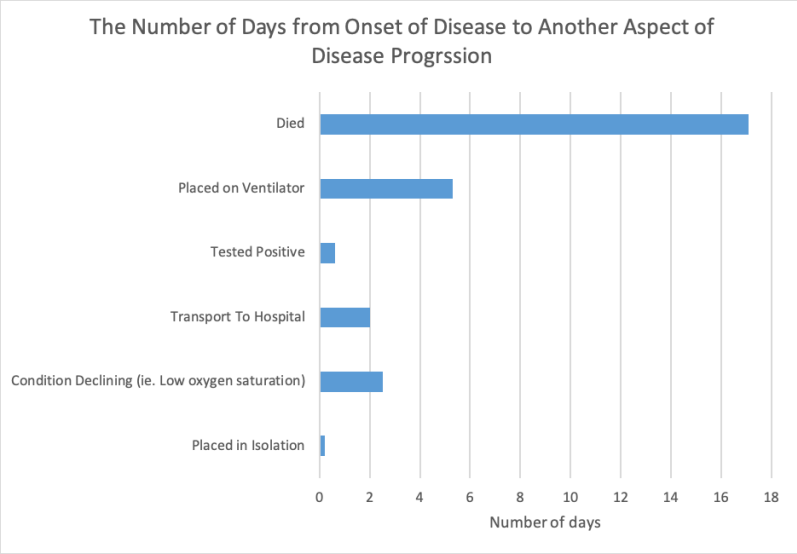
	Placed in Isolation	Condition Declining	Transport To Hospital	Tested Positive	Placed on Ventilator	Died
Cases that Specifically Described that Aspect of Disease Progression	22	84	92	62	67	96

Data and Table: WPF.

For 21% of those who died in BOP facilities, Day 0 included acute respiratory distress syndrome (ARDS) or respiratory failure, requiring immediate hospitalization. The average time for a sick person to be transported to a hospital was 2.5 days, and the average time for patients to be put on a ventilator was 5.3 days. Thereafter, patients died within an average of 17.6 days (Graph 2. 2). The average number of days between first notice of the person's

symptoms and testing positive is less than one day: in fact, 55% of people were not tested until they arrived at the hospital—and this percentage is even higher, 67%, during the first three months March – May (see below Graph 2.2).

Graph 2.2 Average number of days that passed between points of progression of COVID-19, as recorded by the BOP in accounts of 96 incarcerated people who died.



Data and Graph: World Peace Foundation 2020.

Three other studies of disease progression based on clinical research help provide points of comparison: research on progression for a group of patients regardless of outcome, as discussed by the Centers for Disease Control (CDC)[20]; a summary of the literature on patients who became critically ill by George Anesi[21]; and a discussion by Zhou et al of progression for 54 patients who eventually died in Wuhan, China.[22]

Table 2.4: Comparison of disease progression, counted in days.

	Labored breathing	ARDS/ respiratory failure	ICU/Hospital	Ventilator	Death
BOP deaths	N/A	**1.6	2.5	5.2	17.5
Zhou et al	N/A	N/A	11	14.5	18.5
Anesi	6.5	9	N/A	N/A	N/A
CDC	5 to 8	8 to 12	10 to 12	N/A	N/A

***Notes**: CDC, Anesi and Zhou et al, the days are counted from onset of illness or appearance of symptoms. For BOP, the count begins with day BOP claimed it knew of a person's sickness.*

***The BOP number represents the average days based only on the 30 cases that specifically mention a person experienced ARDS or respiratory failure.*

20 Centers for Disease Control, "Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)" June 30, 2020. Available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html. Accessed August 19, 2020.

21 Anesi, George L. MD, MSCE, MBE. "Coronavirus disease 2019 (COVID-19): Critical care and airway management issues," UptoDate. Available at https://www.uptodate.com/contents/coronavirus-disease-2019-covid-19-critical-care-and-airway-management-issues Literature review current through: Jun 2020.

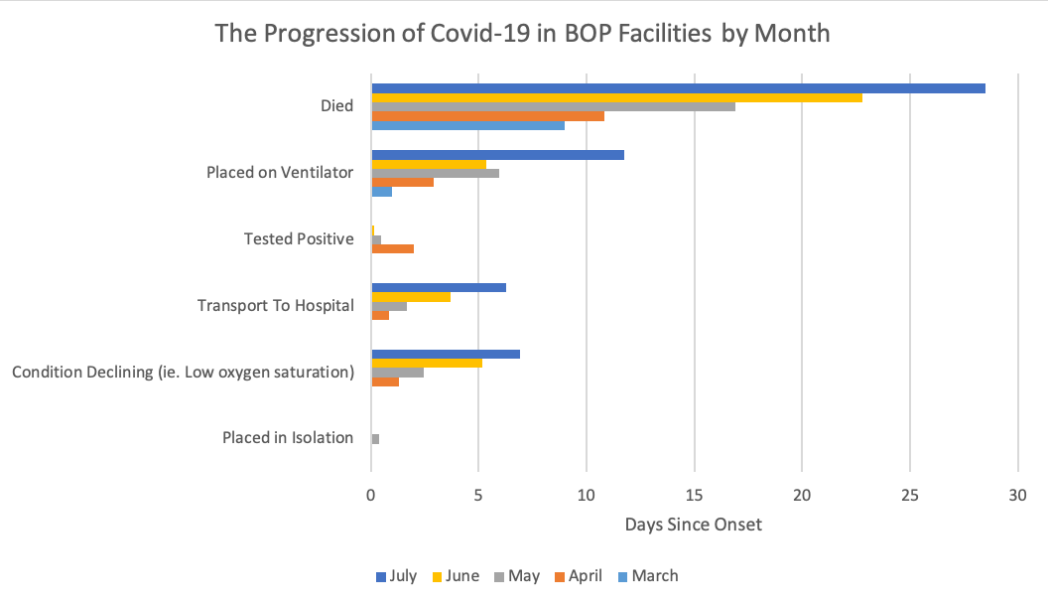
22 Zhou, Fei, Ting Yu, Ronghui Du, Guohui Fan, Ying Liu, Zhibo Liu, Jie Xiang, Weming Wang, bin Song, Xiaoying Gu, Lulu Guan, Yuan Wei, Hui Li, Xudong Wu, Jiuyang Xu, Shengjin Tu, Yi Zhang, Hua Chen, and Bin Cao. "Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study" The Lancet 395: 10229, 1054-1062. March 28, 2002. DOI: https://doi.org/10.1016/S0140-6736(20)30566-3.

There are limits to comparing across the above studies. We include the comparison here to illustrate the general point that the death notices released by the BOP suggest that incarcerated patients were sick longer than the facility reported knowledge of the sickness. In many cases, it appears that incarcerated people only received treatment when the symptoms were well-advanced, as their health declined and while they remained among the general prison population. This is problematic for two reasons. First, for that specific patient, the delay inhibits their right to adequate healthcare and may have contributed to their death. Second, 78% of the people who died were not reported to have been in isolation before their condition deteriorated; suggesting that they were exposing other people (including both other incarcerated people and staff) at the facility to the disease.

Change over time

Overall, the number of people incarcerated by the BOP who have died due to causes related to COVID-19 has declined month by month (Graph 2.3), even as the number of reported infections has increased (likely reflecting increased testing capacity). Additionally, in later months, patients remain longer at each phase of progression, suggesting that the care had improved.

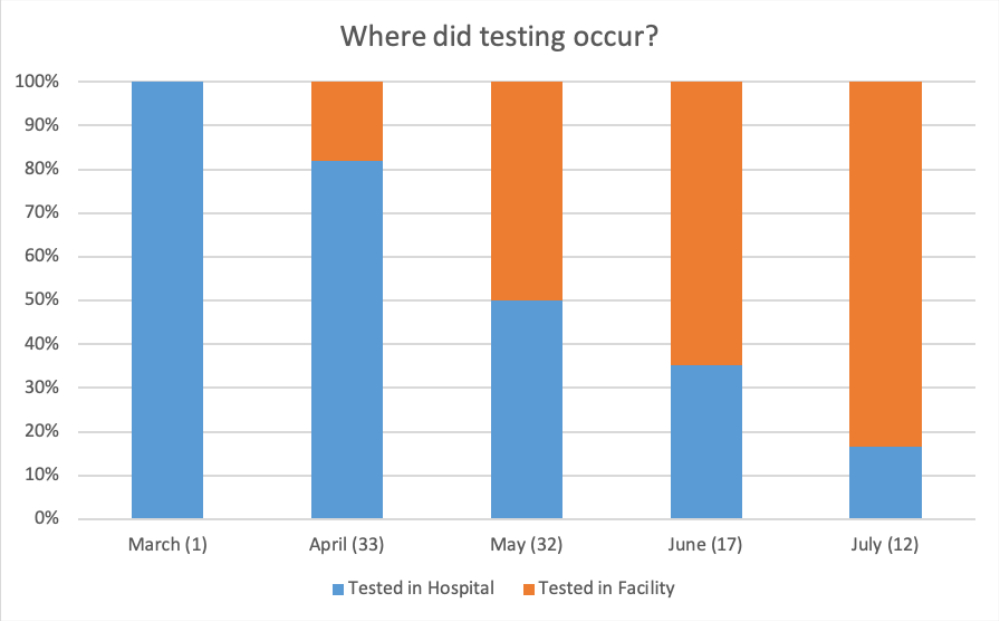
Graph 2.3. Average number of days that passed between points of progression of COVID-19, as recorded by the BOP in accounts of 95 incarcerated people who died; displayed by month.



Data and Graph WPF. ***Note:*** *this chart does not include the case of Darrel Underhill, who died on May 4th at FMC Devens. Due to travel to a hospital for a pre-existing medical, he was placed in isolation 12 days before he was identified as displaying symptoms related to COVID-19. His case pushes the isolation factor for May into negative numbers. See full discussion below, under anomalous cases.*

The results for "placed in isolation" are difficult to see on this graph format, because, of the 22 for whom this occurred, most occurred on Day 0, and are not well displayed on the chart. One anomalous case (Darrel Underhill, discussed in detail below) was in isolation 12 days before he displayed symptoms, due to travel outside prison for medical care related to another issue. Of the 22 people whose death notices discussed whether they had been placed in isolation, most occurred on Day 0. In April, this included all three people. In May, 9 people were placed in isolation on Day 0, one on Day 1, and another on Day 3. In June, all 5 occurred on Day 0 and the same for the 2 in July. It is also important to note that there was only one death in March.

Graph 2.4 Where did testing occur?



Data and Graph: WPF. The number listed by the month is the how many people died during that month.
***Note:** There was one person for whom we could find no information about whether they were tested, although BOP framed their death as COVID-19 related in the press release.*

Testing capacities were limited throughout the country as COVID-19 began to spread—prisons were far from alone in struggling to test at numbers sufficient to prevent community spread. However, a major difference between community spread inside a prison and elsewhere is that vulnerable people, many of whom urgently petitioned the BOP for early release or home confinement, had no options to protect themselves from the virus.

Anomalous cases

We included all people whose deaths were announced by the BOP March – July 2020, because each notice included information related to COVID-19. Within this number were a few anomalous cases.

One person appeared to have caught the virus outside the detention facility. Michael Scarbrough was an 85-year-old man living at FCI Coleman (Medium) in Wildwood, Florida, when he was treated for shortness of breath and difficulty breathing on February 7, 2020. He was transported to a local hospital, and from there to a nursing facility. While at the nursing facility, he tested positive for COVID-19 on July 6th. His condition declined on July 12th and he died two days later.

Three people tested negative for COVID-19 at the time of their death, but BOP still framed the announcement of their death as related to illness. Adrian Solarzano, a 54-year old man held at Terminal Island in California, tested positive on April 16th at the prison. He was placed in isolation until May 10th, when he returned to the general population. Five days later he was admitted to hospital with complaints of chest pain and anxiety. There, he twice tested negative for COVID-19, before he died on May 24th. At FMC Fort Worth, Robert Hague-Rogers was tested on April 21st and 23rd,[23] with negative results. But on April 27th, he saw Health Services, complaining of shortness of breath. He was transported to a hospital, where he tested positive for antibodies, indicating that he had previously contracted the virus. He died on July 3, 2020. Gerald Porter, a 73-year old man, tested positive on May

23 The first positive test result among the incarcerated population at FMC Fort Worth occurred on April 11th. A week later the number was 15, and by the 21st, when Hague-Rogers was tested, there were 21 positive cases reported.

29th; he spent all of June and through July 10th in isolation, but then, following two negative tests, he was returned to the general prison population. Twelve days later he was transported to the hospital where he had a stroke and died on July 29th.[24]

In three cases, incarcerated men were transferred from the prison facility to a hospital due to their worsening condition, but they then improved and returned to the prison. Daniel Morris spent a week in the local hospital, before being released back to FMC Lexington. Eleven days later Morris died at the prison after being found unresponsive. At DCI Seagoville, Jacky Pace tested positive on July 8th and was transported to the hospital the next day. He spent five days at the hospital, returned to the prison, and six days later, was back at the hospital again where he died on July 25th. Michael McDonald was an 80-year old who first fell ill on April 21st. He tested positive in a local hospital and was placed on a ventilator on May 2nd. He returned to FCI Terminal Island on June 10th, and then was re-admitted to the hospital on June 15th, where he died a week later.

One case was complicated because the man, 76-year-old Darrel Underhill, returned to FMC Devens on April 10th, from a local hospital where he received rectal cancer treatment. Following COVID-19 policies about isolating people who move in and out of the prison, he was placed in quarantine. On April 22nd, he developed a fever and returned to the hospital, where he tested positive. He then returned to the prison and was placed in a skilled nursing unit where he received hospice care before dying on May 4th.

III. BEHIND THE NUMBERS: STORIES FROM BOP'S DEADLIEST OUTBREAKS

The death notices only provide us with the BOP's view of the person who died. To expand that view, we searched for media reporting about the people who died.

The death of Andrea High Bear (many news stories and BOP used her married name, Andrea Circle Bear, but her grandmother corrected them) of the Cheyenne River Sioux on April 28th made national headlines. The 30-year-old woman and mother of five was 8.5 months pregnant with her sixth child when she was transferred on March 20, 2020 from a jail in Winner, South Dakota to serve a two-year, drug-related sentence at FMC Carswell in Fort Worth, Texas. On the 28th, she was sent to a local hospital due to potential concerns related to her pregnancy. She was returned to the prison the same day. Three days later, experiencing symptoms of fever, dry cough, and "other symptoms," she returned to the hospital and was put on a ventilator. The next day her baby was born via caesarian section. On April 4th, Andrea High Bear tested positive for COVID-19 and she died two weeks later. The BOP notice explained that she had "pre-existing medical condition which the CDC lists as risk factor for developing more severe COVID-19 disease."

Writing in the Washington Post on May 22, 2020, her grandmother, Clara LeBeau, demanded that the BOP be held accountable. Andrea was sentenced to two years—with participation in drug rehabilitation program she might have been released after one year—instead she was dead and six children lost their mother. Her grandmother was devastated. She wrote:

> *"The last time we spoke, she asked me to tell her children she loved them and told me she was afraid. The prison was putting her in quarantine. The last time I saw her, it was on a video call from the local hospital where she'd been moved, and she was unconscious. I asked the nurses to hold the phone to her ear and told her to wake up."*

24 There is evidence that Covid-19 increases the likelihood of strokes, see Merkler, Alexander E., Neal S. Parikh, Saad Mir, et al. "Risk of Ischemic Stroke in Patients With Coronavirus Disease 2019 (COVID-19) vs Patients With Influenza" JAMA Neurology, July 2, 2020. doi:10.1001/jamaneurol.2020.2730.

As her granddaughter entered the BOP system, LeBeau explained, information dried up:

> *"There are so many things the BOP never told us as they were happening: that Andrea was moving out of quarantine to a hospital, that she had covid-19, that she was dying. Any information I ever got was from the hospital, not Carswell…. Families like ours are trying our best. We call wardens, prisons and jails every day. No one calls back."*

The BOP reported no more than two positive cases among the incarcerated population at FMC Carswell through the end of June. But on July 2, the number jumped to 25; a week later it reached 80; one more week, on July 16th it was at 181. Another two women died there: Sandra Kincaid, a 69-year old white woman died on July 15th, and Teresa Ely, a 50-year-old white woman who died on July 20th. By early August, the prison reported 1323 people tested, of whom 542 were positive, with 150 active cases and 392 recoveries.

While Andrea High Bear's death received more media attention than many of the 96 who died while incarcerated by the BOP, elements of her story repeat in journalists' accounts of others' deaths. These include: failure to effectively safeguard people entering the BOP system during the epidemic, people incarcerated on lengthy sentences for drug-related offenses, lack of communication with family members, and the laborious and slow review process for home confinement and compassionate release. Below, we profile another eight incarcerated people who died while in BOP custody, drawing on journalists' accounts.

Like Andrea High Circle, Douglas Allen Reid contracted COVID-19 within weeks of entering the BOP system. He entered custody on March 26, 2020, held at Oklahoma's Federal Transfer Center, on his way to FCI Beaumont-Low, but he never left. He displayed symptoms on April 20th, was isolated, and tested positive on April 23rd. A week later, he was transported to the local hospital where he died on May 4th.

Many people who died were incarcerated for drug-related crimes: arguably, some cases warranted drug recovery programming, and, in some cases, people may have received shorter sentences today, following criminal justice reform, than when they were sentenced. For instance, the first person to die of COVID-19 related causes in BOP custody, Patrick Jones, was serving 27 years for a drug offense. He tried to get the sentence reduced following criminal justice reform under Pres. Obama, but was denied. He died on March 28th.

Perhaps the most egregious example of someone who died in custody while serving a long prison sentence despite subsequent changes to the law is Fidel Torres. Torres was a 62-year-old man who had less than two years remaining on an 18-year sentence for a marijuana distribution conviction. In 2006, Torres' lawyer reported that he had diabetes and was going blind, but BOP had no record of these medical details.[25] He died in a local hospital on May 20th.

Another repeated theme across cases is the BOP's lack of communication with families, even while their incarcerated loved ones were dying. Margarito Garcia-Fragoso, had one more year to serve on a sentence. When the COVID-19 epidemic began to spread, his lawyer filed a motion for home confinement. His daughter, Olivia Garcia, was waiting for news about the motion, when the wife of another incarcerated person contacted her to say that her father was having difficulty breathing and had sought medical attention. After calling the prison, she was informed that her father was on a ventilator in the ICU at a local hospital, which prison officials refused to identify. On April 1st, she learned that her father's condition had deteriorated, and he died two days later.

The family of Richard Nesby, a 55-year old Black man, similarly tried to advocate on his behalf, as he had a pre-existing condition that rendered him more vulnerable to COVID-19. The family was not allowed to speak to

25 Reilly, Ryan J., "Man serving 18 years on marijuana charges just died in federal prison COVID-19 outbreak," Huffpost, May 22, 2020. Available at: https://www.huffpost.com/entry/covid-federal-prison-marijuana_n_5ec6c5fcc5b6cbe70930a988.

him as his condition deteriorated, and his daughter could visit him at the hospital only once he was on a ventilator. He died shortly thereafter, on April 26th.

George Escamilla, a 67-year-old man, who had served 12 years of a 16-year sentence, was wheelchair-bound as a result of losing both legs to complications from diabetes. He was one of the federally incarcerated people who in mid-March applied for and received a positive response to his motion for release to home confinement. He was given a release date of May 6th. He died of COVID-19 related causes on May 8th.

Jones, Garcia-Fragoso, Nesby, and Escamilla were held at FCI Oakdale, where, by the end of July, 181 incarcerated people tested positive and seven died.

The family of 56-year-old Guadalupe Ramos sought to get him out of FMC Forth Worth on compassionate leave, and thought it might have been granted, as he had diabetes. On April 23rd, he called his niece, one of his listed emergency contacts, to tell her he had tested positive for COVID-19. Two days later, the wife of another incarcerated person called with the news that Ramos was rushed to the hospital. Ramos' family later learned he had "coded" for eight minutes before being revived. After that point, he never recovered.

Andre Williams Sr. had severe coronary disease and had served 16 years when the judge who sentenced him ordered him out as the COVID epidemic began, saying he didn't deserve to die behind bars. His son, Williams Jr. was driving to FCI Butner prison to take his father home, when his mother called. His father had just died. Williams was far from the only person who might have been more quickly released, possibly saving his life; the Washington Post reported in their August 3rd story on Williams: "The Bureau of Prisons said 25 people have died in its custody this year while their requests for sentence reduction were under consideration, including 18 since March 1, around the time the coronavirus began spreading in U.S. communities."

The problems described above repeat across BOP's facilities and present hurdles for thousands more than just those who eventually died.

A final issue that appeared in only two cases that we could document, but which raises a concern if it is more widespread, were men who rushed to a hospital within hours of being released from prison and died shortly thereafter. Efrem Stutson, a 60-year-old man serving 27 years for selling cocaine, was released under a federal program designed to reform prison sentences for low-level drug offenses. Stutson called his family one week before his scheduled April 1st release from USP Lompoc, excited and relieved to be leaving. He became ill, but nonetheless was put on a three-hour Greyhound bus ride to San Bernardino, where his sister met him. By that time, he could "hardly hold his head up." He died four days later.

A second person was Alan Hurwitz, a 79-year-old man who was not tested before being released from Butner (unclear which Butner facility) on May 20th, although a person incarcerated with him recalled that Hurwitz was visibly ill. During a lay-over on his flight home to return to his family, airline officials called an ambulance for him, as he had a spiking fever and chest pains. He died in a hospital on June 6th.

Neither is included in the BOP's reporting on deaths.

IV. CONCLUSION

Public officials across the country and around the world have struggled to respond to the pandemic, with greater and lesser degrees of success. Likewise, populations around the world have selected behaviors, some by necessity and some by choice, that either increase or decrease their potential exposure to COVID-19. Some of the deadliest and largest outbreaks have occurred in group living settings, where people have combinations of increased vulnerabilities and decreased capacity to change their behaviors.

Prisons are by design housing structures where people have many restrictions to the actions they can take, including actions to protect themselves during an epidemic. The responsibility of those in charge of prisons and other detention centers increases, therefore, during a public health crisis. Further, regardless of what someone has done—although, as organizations like the Innocence Project have proven time and again, not all people in prison are rightfully there—most, and all of those who died of COVID-19-related causes, are not sentenced to death. All people, even those who recover or who never get sick, deserve to be treated with basic dignity and care. Maintaining a level of basic humanity is a measure of those in charge of prisons and the society on whose behalf people are incarcerated.

The notices of deaths released by the Bureau of Prisons provide a unique source of insight into the medical care that has been provided to people incarcerated by the federal government during the most acute and widespread public health crisis of a generation. They reveal substantial shortcomings that are an indictment of the Bureau, the Department of Justice, and the current Administration, and the American public that has proven too willing to write off the lives of millions of incarcerated people.

ADDITIONAL RESOURCES

Journalism

The Marshall Project and Vice News investigative report, "'I begged them to let me die': How Federal Prisons Became Coronavirus Death Traps," by Keri Blakinger and Keegan Hamilton. June 18, 2020. Includes video revealing conditions for sick people inside BOP prisons, analysis of internal Bureau memos, interviews with incarcerated people and staff, and overviews of the hardest hit prisons.

The Intercept: Reporting by Liliana Segura, with Including a series of articles on Residential Re-Entry Centers, or halfway houses, notable the underreported outbreaks at facilities managed by GroGroup. Another key contribution is Nick Pinto's June 21st article about MDC Brooklyn, "Revealed sick-call requests from a federal jail show people desperate for medical attention amid the pandemic—and waiting weeks to get it."

Reporting by Walter Pavlo, with Forbes Magazine. He has written on BOP release policy, the use of solitary confinement, and Federal Courts' decisions that relate to the BOP, among other issues.

Policy and Research

The American Civil Liberties Union and its various state chapters have brought cases against federal facilities as well as state prisons, on behalf of incarcerated people, both before and during the pandemic.

The Brennan Center program on Ending Mass Incarceration has compiled policy and advocacy responses detailing how different levels of the criminal justice system have responded to the pandemic, including policy recommendations directed at law enforcement, prosecutors, criminal courts, corrections agencies, and immigration agencies.

Families Against Mandatory Minimums, the organization has encouraged all people in federal prison who are most vulnerable to immediately apply for early release, and state and local governments to use their authority to release sick and elderly people as quickly as possible. It also has a list of actions people can take to support release of the sick and elderly.

The Prison Policy Initiative is a non-profit, non-partisan organization that engages in research and advocacy related to criminal justice reform. It has tracked pandemic-related criminal justice issues and produced a set of policy recommendations.

The Vera Institute of Justice program on Ending Mass Incarceration has produced guidance for leaders at all levels of federal, state, and local government to immediately address the looming COVID-19 crisis behind bars.

APPENDIX I. BOP ABBREVIATIONS

For additional information about prisons and other BOP-managed facilities, visit: https://www.bop.gov/about/facilities/

ADX	Administrative-Maximum U.S. Penitentiary
CI	Correctional Institution (a private facility)
CO	Central Office
FCC	Federal Correctional Complex
FCI	Federal Correctional Institution
FDC	Federal Detention Center
FMC	Federal Medical Center
FPC	Federal Prison Camp
FSL	Federal Satellite Low
FTC	Federal Transfer Center
MCC	Metropolitan Correctional Center
MCFP	Medical Center for Federal Prisoners
MDC	Metropolitan Detention Center
RO	Regional Office
RRC	Residential Reentry Center
RRM	Residential Reentry Management Office
SFF	Secure Female Facility
SCP	Satellite Prison Camp
USP	U.S. Penitentiary

APPENDIX II.

Names of all those who died. Where additional information about the person is available, we have provided a link.

Date of Death	Name
28-MAR	Patrick Jones
1-APR	Nicholas Rodriguez
1-APR	James Wilson
2-APR	Margarito Garcia-Fragosa
2-APR	David Townsend
2-APR	Frank Russell McCoy
2-APR	Woodrow Taylor
11-APR	Woodrow Taylor
2-APR	Wallace Holley, Jr.
9-APR	George Jeffus
12-APR	Gary Edward Nixon
12-APR	Andre Williamas
13-APR	Alvin Turner
13-APR	Bradley James Ghilarducci
13-APR	John Doe
14-APR	David Ehle
15-APR	Michael Lilley
16-APR	Fabian Tinsley
16-APR	William Hutsell
17-APR	Oliver M. Boling
18-APR	Anthony David Gentile
19-APR	Michael Fleming
30-APR	Willie Peterson
22-APR	Arnoldo Almeida
24-APR	Oscar Ortiz
24-APR	John Ng
25-APR	Donnie Grabener
26-APR	Richard Nesby
27-APR	Daniel Kimbrough
28-APR	William Walker Minto
28-APR	Andrea Circle Bear
29-APR	Stephen Cino
29-APR	Rex Damon Begay Sr.
30-APR	Leonard Auerbach
2-MAY	Kevin Ivy
2-MAY	Douglas Allen Reid
2-MAY	Randy Bise

4-MAY	Darrel Underhill
4-MAY	Eduardo Robles-Holguin
6-MAY	William E. Miller
6-MAY	James Druggan
6-MAY	Jimmie Lee Houston
8-MAY	Michael Brookwalter
8-MAY	George Escamilla
9-MAY	Scott Douglas Cutting, Sr.
10-MAY	Guadalupe Ramos
11-MAY	Juan Mata
11-MAY	Vernon Adderley
12-MAY	Thomas Rogers
13-MAY	James Lino
14-MAY	Carlos Calderon Mendoza
14-MAY	Richard Saettel
15-MAY	Charles Hanberry
15-MAY	Jerry Lynn Dempsey
17-MAY	Bich Tran
19-MAY	Joseph Young
20-MAY	Fidel Torres
24-MAY	Adrian Phillip Solarzano
24-MAY	Gregory Phinton Glenn
25-MAY	Eric Spiwak
25-MAY	Mohamed Yusuf
26-MAY	Isaac Lamar Byers
26-MAY	Emanuel Brewster Jr.
28-MAY	Dongfan Greg Chung
28-MAY	Bernardo Luis Olarta-Loaiza
30-MAY	Steve Arthur Robinette
31-MAY	David Grant
1-JUN	Daniel Lee Vadnais
1-JUN	Juan Ledoux-Moreno
2-JUN	Robert Herndon
3-JUN	Stephen Cook
3-JUN	Bobby Lee Medford
4-JUN	Andrew Charles Markovci
4-JUN	Dewayne Antonio Mitchell
5-JUN	John A. Brust
9-JUN	Charles M Woolsey
10-JUN	Robert Hoffman
13-JUN	John Marrone

14-JUN	Mark E. Hebert
20-JUN	Wayne Delvin Littlecrow
21-JUN	Michael McDonald
23-JUN	Joe Tapia, III
24-JUN	Norman F. Grimm, Jr.
22-JUN	Ivan Gonzalez Ramirez
1-JUL	Daniel Morris
3-JUL	Robert Hague-Rogers
3-JUL	John Dailey
5-JUL	Jack Edward Telledo
12-JUL	Malcolm L. Scarbrough
15-JUL	Sandra Kincaid
16-JUL	James Giannetta
20-JUL	Teresa Ely
22-JUL	Romie Roland
25-JUL	Jacky Pace
28-JUL	Mark Stamps
29-JUL	Gerald Porter

Note: Another 11 people have died by time of publication (August 26, 2020).