Event Transcript In Conversation with Roger Mitchell

Sandro Galea:

Welcome to our latest Public Health Conversation Starter. My name is Sandro Galea. I have the privilege of serving as dean at the Boston University School of Public Health. These conversation starters are a series of discussions we are having with thinkers who provide a critical perspective on the work of public health.

Today, I have the honor of welcoming Dr. Roger Mitchell. Dr. Mitchell's a professor, and chair of pathology at Howard University College of Medicine. He also serves as the chief medical officer for the Howard University Adult Ambulatory Care Center, and chair of the Task Force on Gun Violence Prevention for National Medical Association.

From 2014 to 2021, he served as chief medical examiner for Washington DC. During his tenure, Dr. Mitchell was the only forensic pathologist in history to also serve in a dual role as interim deputy mayor for Public Safety and Justice. Now, we have Dr. Mitchell today joining us to talk about his book, Death in Custody: How America Ignores the Truth, and What We Can Do about It. The book was written with Jay Aronson. It addresses undercounting of deaths among those who die in custody in the US.

As I told Dr. Mitchell earlier, I thought the book was terrific. It was provocative. At times, truly heartbreaking. I'm really honored to be here with Dr. Mitchell. Dr. Mitchell, thank you for being here. Thank you for writing this book.

Roger Mitchell:

It's great to be here.

Sandro Galea:

Thank you. Let me start. Let's start going back a little bit before we get into the book. Tell us a little bit about your background. Tell us a little bit about how you came to be doing the work you're doing.

Roger Mitchell:

I went to undergraduate here at Howard University. That's where I started this pursuit of social justice and medicine. I'm a native of New Jersey, born and raised. I left the undergrad at Howard, and worked for the FBI for a little bit. I was a forensic scientist for the Federal Bureau of Investigation back in the late '90's before medical school.

I left the FBI to study violence as a public health issue. I was exposed to critical incident stress management, post-traumatic stress disorder, and some of the work of David Satcher on youth violence. During that time when he was our surgeon general, and made a decision to go on to medical school, went to Rutgers or UMDNJ, New Jersey Medical School.

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It was in my first year of medical school, when I was home preparing dinner, was watching the news. Breaking news, Amadou Diallo was shot at 41 times, hit 19. He had entrance wounds in the soles of his feet. He was an unarmed man in the vestibule of his home, because he fit the description. We were about the same age. This was about 25 years ago in February of 1999. Then that changed the game for me. That really changed my perspective.

I said, "If violence is a public health issue, then at the time we were calling police brutality. Police brutality is a health issue." I wrote a position paper that was published in the Journal of the Student National Medical Association on police brutality as a health issue. Shout out to your students, and students that have ideas at the time in which they're being educated. Now, 25 years later, we're still doing the work. We've been doing the work for a while.

Sandro Galea:

Let me go to your book. In the introduction, I'm reading a sentence in the very first page. "The United States of America is experiencing a public health crisis, the scale of which is intentionally obscured by government inaction, and outright obfuscation."

Lead us through why deaths in custody is a public health crisis. Lead us through a little bit what you think is the real scope of this challenge.

Roger Mitchell:

We know that there are thousands upon thousands of American citizens that are finding themselves in connection with law enforcement. Whether that law enforcement actually leads to incarceration for any short or long period of time, notwithstanding. We have a lot of our communities that come into contact with law enforcement. In custody or death in custody occurs over a continuum.

It starts in the pre-arrest related phase, and then it travels from the arrest related to incarceration, jail and in prison. Each time during this continuum, there is a risk of injury or death. You take a car chase, for instance. There is an opportunity for a motor vehicle collision that can lead to the death of not only the individual being pursued, but law enforcement themselves. Then when you have an individual that comes into contact with the law enforcement, and there's an altercation, or there's gunfire exchange, that can lead to a death.

Then you have the whole milieu of our carceral system and the healthcare delivery that occurs or doesn't occur within our healthcare, within our carceral system. We know that the majority of deaths that occur in our carceral system are natural deaths, followed by suicides, and then drug overdoses are on the rise within our carceral system.

As a forensic pathologist, as an individual who really studies death, and determines cause and manner of death for a living, I believe that mortality gives us a great view into those individuals that are suffering from that disease or injury, which is morbidity. The scope of this problem is vast. It hasn't been looked at through a true comprehensive lens of public health. We know that it hasn't, because there's no data collection surrounding it.

We know that the pin within the wheel of public health is data collection. Quite frankly, the majority of our public health initiatives start with how many people are dying from this disease or injury. If we want to study prostate cancer, we study how many people are dying from prostate cancer. Then we back ourselves into treatment and prevention. Same thing with maternal mortality. When we identify that Black women are dying at a higher rate from in and around pregnancy, we're looking at mortality, and then backing ourselves out to improved care delivery.

Looking at mortality, and looking at death to solve a problem of access to care is not a new phenomenon when it comes to public health. Matter of fact, that is the approach that most of us take. We study cancer death, when we're talking about a moonshot for how we determine whether or not cancer is being resolved, is how long are people living with, or how can we cure people from, because we know that some cancers have a death sentence that occurs with it. This is a huge public health issue that we have just started to scratch the surface, because we're now having conversations about the care that individuals are getting in this invisible environment we call the criminal legal system.

Sandro Galea:

I thought one of the most affecting parts of your book is you make it clear that the challenge of people dying preventable deaths in custody is not something that has emerged suddenly, but it's a product of a long history of injustice. I thought your pieces about this were really moving. Can you just talk a little bit about that history, and how it led to the present crisis?

Roger Mitchell:

We start off the book, and this was a bit of a pulling tug between Jay and I, Dr. Aronson, who is a professor of human rights at Carnegie Mellon, and now a great friend. We wrote this book over a six-year period of time. We started the book off with a chapter on lynching.

We talk about lynching from a couple vantage points. But the two main vantage points is one, the individual, particularly in the form of Ida B. Wells, a journalist who started giving name, and started giving constitution to the individuals that were dying, and

their of lynching. Making it plain to the general public that individuals were not getting their day in justice. They were being hanged from trees, and from poles, often in multiples, pregnant women, part of their body parts being removed as memorabilia, postcards being generated as reminders of that Sunday picnic that the family went to, to see the lynching.

We paint a picture of the journalist who really created a groundswell, and was even one of the founders of the NAACP. A lot of people don't realize, a part of the founding of the NAACP was an anti-lynching movement. We tell the story of her, how she came to be, how this information came to be, and how lynching fell out of vogue per se in the criminal justice system. This vigilante system was being squelched because of the need to count, and recognized how many people are dying.

The other piece that we talk about is the coroner's role in that. Being a medical examiner, a coroner is another name for a different type of medicolegal death investigation system. One that is not a physician, but has the responsibility of establishing cause and manner of death. We talk about the antebellum lynching era where the coroner's inquest would often find the individual as death at the hands of unknown persons.

We're talking about a flyer that will go around to the community, telling the community to come watch the lynching. Individuals engaging in the lynching, sometimes even the mutilation, and sometimes even the shooting of these individuals. But yet when it got to the coroner, the coroner would often obfuscate this process by saying, "Hey, we don't know what happened here."

We fast-forward to 2024, where there are still diagnosis of excited delirium of individuals that are in altercations with law enforcement, and their deaths being called undetermined or accident when it's clear that the actions, whether intended or not, the actions of that law enforcement or correctional officer led to the death of an individual. We make those connections within the book. We make the historical claim that this is not a new phenomenon of what we're seeing today, but it is an opportunity for us to learn from the history by giving these individuals names, and giving these individuals agency.

Sandro Galea:

Before we move to epidemiology, I want to stick with stories for a second. Because I think your book does such a nice job of talking about stories, and interweaving them with some of the signs that we need. There are many affecting stories in the book, but one of those is the stories of Earl Faison who comes in chapter 2. Can you just talk a little bit about what happened to him, and how the story echoes on the challenges we're facing today?

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Roger Mitchell:

So Earl Faison was in his mid to late 20's. He was an aspiring artist. He was caught up in a dragnet operation that was happening in the northern part of New Jersey, the East Orange and Orange, Newark part of New Jersey, and Essex County. An officer was killed by an unknown man. That officer was shot and killed. There was a lot of emotion to try to find who may have killed this officer. A joint task force was going into poor Black communities, looking for someone who fit the description. They came across Earl Faison.

Earl Faison had a weapon on him, so he ran from law enforcement. They caught him. They beat him. They beat him so bad that witnesses suggested that one of the law enforcement officers took a running start, and kicked him in his head like he was trying to kick a field goal. Then he was brought into the local jail, and maced multiple times in his throat. He died. He was taken to the local medical examiner where that local medical examiner called him complications of asthma. It was clear that he was beaten, and beaten to death. But that local medical examiner under really political pressure called that case undetermined.

It's a good example of how altercations with law enforcement can be construed to be something that they're not. Matter of fact, it was clear that many of those law enforcement officers lied about that altercation, and indeed they killed him. Subsequent medical examiners reviewed all the records, and indeed they killed him. Even when I was chief medical examiner of the northern region, I had an opportunity to review that record. It's clear that they killed him.

Where we stand now, and why this becomes even more of an opportunity for us to get these cases correct, and get them right is with the advent of body worn camera footage. Now with body worn camera footage, and cellphone footage, we can actually see what's happening in these interactions with law enforcement.

It's an objective way. In the past, the medical examiner and coroner is really at the will of what is being told to them. But I led a group of forensic pathologists in writing the position paper that tells forensic pathologists how to investigate, and examine those that are dying in custody. Part of that rubric is to make sure that you have access to all of the body worn camera, all of the objective footage to be able to make these designations of the circumstances.

Earl Faison echoes. I was a medical student when Earl Faison died. He actually died only several months after Amadou Diallo.

Sandro Galea:

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Tell me a little bit about how you think we can reimagine our policing, and prison system more broadly to reduce deaths in custody today.

Roger Mitchell:

I think we need to be looking at it all the time. The Office of the Inspector General for the Bureau of Prisons, just put a report out. He talked about the lackluster performance of the Bureau of Prisons in providing prevention related constructs, like hourly rounding on the prisoners that are at risk. Still putting individuals in solitary confinement when they have suicide risk. We know that solitary confinement is not the place for an individual that has suicidal ideation. It's clear, but it's still happening.

Some of the ergonomic approaches to ensuring that garbage liners are not available, rippable sheets aren't available when we're talking about suicide, creating fail safes to ensure that contraband is not still getting into our prisons. Contraband into our prison system leading to substance use and abuse, and a death from substance use and abuse is a big problem. But yet substance abuse treatment is not readily available in our correctional system, but the contraband finds its way there. I find something wrong with that.

The other big thing, if we're talking about really providing value-based care, because that's the big buzzword for those of us that are providing community-based care, is the fact that there's a law called the Medicaid Inmate Exclusion Policy. Medicaid Inmate Exclusion didn't make it to the book. This is something that I started working on since the book has been completed. This limits the fact that you can't get Medicaid while in jails or in prisons.

Those metrics, even a standard electronic health record, is not available within our criminal legal system. The scope of monitoring, evaluation, reform, data collection and evaluation, and prevention and improvement, the things that we know we need to be doing in community health, and how we deliver healthcare to our communities that are disenfranchised, and marginalized, on the outside of the jails, those best practices need to be implemented inside the jails and prisons. Quite frankly, in how we handle that. Now, that's the healthcare piece.

Now, the criminal justice piece, how we actually engage individuals, how we're over-policing minoritized communities, and over-policing poor white communities, these policies and philosophies of criminal justice, they need to be updated with mental health providers, violence interrupters, and individuals that are working through the access to the social determinants of health. Through an equity lens, all of this can improve our policing system as well.

Sandro Galea:

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In your book, you and Dr. Aronson, you argue for a checkbox added to the US standard death certificate to record whether death occurs in custody. You make the argument that this gives us a clear picture, allows the epidemiology of these deaths to be easier.

Can you comment a little bit both about that, but also what other regional, and national standards you think we should be adopting to make sure that all deaths in custody are counted to the end, obviously, of stopping deaths in custody?

Roger Mitchell:

Yeah. I'm glad that you added that. Because it's not a panacea. Just the data collection is not going to stop the deaths. You have to use that data in a way that allows for prevention. But a checkbox on the US standard death certificate or checkbox on the local death certificate allows for us, knowledge of the general demographics: age, race, gender, geography, jurisdiction, circumstances, surrounding that death. We know it works.

There was a time when individuals didn't wear seat belts. It's a time where we didn't wear helmets when we were on bicycles. The reason why there's a Vision Zero initiative by the Department of Transportation in pretty much every major urban center in this country is because there is a series of check boxes surrounding motor vehicle collisions. Whether or not that individual is a pedestrian, whether or not that individual was a passenger, a driver, a bicyclist, or a motorcyclist, all that's found on the death certificate.

A lot of people don't know that, because they don't sign death certificates for a living. I do. We know that that data is reliable. We know that the data is so reliable on a death certificate, that we used the death certificate to track COVID. I ran all fatality management for Washington DC. during COVID, thousands of individuals that died from COVID.

The CDC had webinars for those that signed the death certificate to say, "Hey, we want you to sign the death certificate like this. These are the words that we want you to use when you think it's a COVID-related death." So that we had uniformity of practice on how to sign those death certificates, that we could track those death certificates in real time, and provide you those beautiful dashboards that every academic center in every city was creating, so that we could understand who's most at risk from COVID.

That's how we got to the elderly, African American individual, the disparity in COVID, because of death certification. We were signing those. We turned that on immediately, Doc. We turned that on immediately.

Another great example is the opioid epidemic. That opioid epidemic, we wouldn't have known that fentanyl was a predominant reason of the opioid fatality epidemic if the CDC didn't say, "Hey, stop putting mixed drug toxicity on your death certificates. Please list out every single medication that's in the body of the individual that died, so that we can start tracking what are the actual toxins that are causing death."

We started doing that. We were able to see that heroin, fentanyl, methamphetamine, and cocaine were being used in a lot of these deaths. Those are the things that are being used to create prevention. Utilization of the vital record in the form of the death certificate is a known public health solution to understanding a disease or injury in this country.

There's a smoking checkbox on the US standard death certificate. That's why we know smoking is associated with certain types of cancers. All of these things help us start gathering the data. I'm not saying that the Department of Justice through the Deaths and Custody Reporting Act, which is law that requires the Department of Justice to collect this data, I'm not saying that they shouldn't be held accountable to collecting that data appropriately. But what I'm saying is that our health and human services, our public health infrastructure, our Center for Disease Control, our National Vital Statistics registry, we need to be collecting data on individuals that are dying in custody.

The other things that we should do is, again, when we're talking about understanding fatalities, there are things called fatality review boards. These fatality review boards are multidisciplinary. They're usually at a health and human services, at a state level. They're pulled together, a group of individuals. These cases are reviewed from the level of education of the individual that died, to their jobs, to how many times they came into contact with the state for whatever services that may have been rendered, to the circumstances surrounding their death.

A group of individuals would sit down, and make recommendations. Was there opportunity for life to be saved? Is there opportunity for better, and more appropriate policy and programs to happen at a state local level that can lead to better health outcomes for people in the future? That's a known way. Infant fatality review and child fatality review are mainstays, and creating prevention constructs for sudden death among young people and infants. Domestic violence fatality is also a mainstay, and maternal mortality.

We believe that if we create fatality reviews, create a registry, and a clear way of documented deaths in custody, then the rest of us, individuals, are smart people that are going to use this data, and are going to develop recommendation, can create recommendations, and programs to put in front of policy makers and government officials to be able to create change in community.

Sandro Galea:

I think you and I could talk for hours, but I'm going to ask you just one last question. You deal with some pretty heavy topics on a day-to-day basis. What gives you hope?

Roger Mitchell:

Wow. The first thing, when you said hope, I thought about my children. I have three. I have a 21-year-old son who's in theater arts, a 19-year-old daughter who's pre-med, and a 17-year-old who wants to be an international business guy when he leaves high school. I think about them. I think about my wife. I think about my faith. I think about my community. I think about connecting with people like you, that have a mind towards justice, have a mind towards collaboration.

I don't think we're done yet, even in the midst of the milieu of what's coming at us from each and every aspect, and all the underbelly of our society that I see on a regular basis. There are people that are hopeful. There are people that want to make change. There are people that want to engage. Then there's families. I have a family that loves me. I love them back. That gives me hope.

Sandro Galea:

Dr. Mitchell, thank you for writing this book. Thank you for what you do. I learned from it. I really learned from speaking. Thank you for everything.

Roger Mitchell:

I appreciate you. Your listeners and watchers can go onto www.deathincustody.com, and get your copy.

Sandro Galea:

Thank you.