HOUSE DOCKET, NO. 2919 FILED ON: 1/16/2025

HOUSE . . . . . No. 1745

The Commonwealth of Massachusetts

PRESENTED BY:

Christopher Hendricks

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act to study the delivery of medical care to persons held in custody.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Christopher Hendricks	*11th Bristol*	*1/16/2025*

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HOUSE . . . . . No. 1745

By Representative Hendricks of New Bedford, a petition (accompanied by bill, House, No. 1745) of Christopher Hendricks for legislation to study the delivery of emergency medical care to persons in custody. The Judiciary.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Fourth General Court
(2025-2026)

An Act to study the delivery of medical care to persons held in custody.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Definitions:

(a) "Law enforcement officer", "Law enforcement officer" or "officer", any officer of an agency, including the head of the agency; a special state police officer appointed pursuant to section 58 or section 63 of chapter 22C; a special sheriff appointed pursuant to section 4 of chapter 37 performing police duties and functions; a deputy sheriff appointed pursuant to section 3 of said chapter 37 performing police duties and functions; a constable executing an arrest for any reason; or any other special, reserve or intermittent police officer .

(b) "Correctional officer", any officer with supervisory, custodial, or other control responsibilities within a correctional agency.

(c) "Correctional agency", the Department of Corrections, a House of Corrections, or a jail.

(d) “Emergency medical condition” a medical condition, whether physical, behavioral, related to a substance use disorder, or mental, manifesting itself by symptoms of sufficient severity, including but not limited to severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part .

(e) “Custody”, the detention of a person who is under arrest, is en route to be incarcerated, or is incarcerated at a correctional agency, including but not limited to a municipal or county jail, state prison, or other local or state correctional facility (including any juvenile facility).

(2) Findings:

(a) Custodial deaths are poorly understood, not accurately tallied, and often involve the provision of medical care that was neither adequate nor timely.

(b) Avoidable custodial deaths pose a significant public health burden, costing needless loss of life and billions in taxpayer dollars, while contributing to loss of trust in law enforcement and correctional officers, thus giving rise to violence against such officers.

(c) The Death in Custody Reporting Act of 2013 (“DCRA of 2013”), which reauthorized a federal law first passed in 2000, requires states that accept certain federal funding to report to the U.S. Department of Justice about who is dying during arrest, en route to be incarcerated, or when incarcerated at a correctional agency, such as a municipal or county jail, state or federal prison, or a local or state correctional facility (including any juvenile facility).

(d) While the DCRA of 2013 was intended to establish an opportunity to improve understanding about why deaths occur in custody, and to develop solutions to prevent avoidable custodial deaths, its implementation has not and cannot meet these objectives. The DCRA of 2013 only reports counts of such deaths, accompanied by limited factual circumstances surrounding each death.

(e) Currently, it is not possible to systematically study the delivery of medical care to persons held in custody, which is vital to understanding why people die in custody.

(f) Importantly, there are no other state or federal laws, nor reporting requirements, that facilitate the accrual and reporting of relevant clinical pre-mortality data.

(g) Poor understanding of the delivery of medical care, and the medical conditions experienced by persons held in custody, prohibit implementing solutions to advance better health outcomes and to contain costs associated with litigation, which seeks to compensate for poor medical outcomes and wrongful deaths in custody.

(h) Further, the prevalence, nature, and patterns associated with emergency medical conditions experienced by arrestees and inmates cannot be studied due to limits in existing data reporting requirements.

(i) Psychiatric crises are also not understood or studied in these circumstances, except for counts of suicides, which are reported pursuant to the DCRA of 2013.

(j) The failure to study emergency medical conditions prohibits understanding whether medical needs have been adequately, timely or competently met.

(k) The absence of such data hampers the appropriate allocation of state and federal resources as well as appropriate or necessary legislative and policy changes.

(l) A significant number of custodial deaths are preventable with timely competent emergency medical care. In 2024, the U.S. Department of Justice Office of the Inspector General identified that nearly one half (48%) of the custodial deaths evaluated in Bureau of Prison (BOP) prison facilities involved insufficient emergency medical responses.

(m) This report should be the impetus for Massachusetts to study whether similar delays occur during custodial arrest, in local jails and in state prisons.

(n) An annual study of the delivery of emergency medical care to persons held in custody would allow Massachusetts to make informed decisions about state and federal spending.

(o) A data collection that seeks to accrue and to report such data is ultimately vital to understanding not only why custodial deaths have occurred in the prior fiscal year but to advance better health outcomes; build trust in law enforcement officers; and to prevent exponentially rising costs associated with custodial deaths.

(3) Reporting:

(a) Not later than 365 days after the date of enactment of this Act, the state administering agency (SAA) for the Death in Custody Reporting Act (DCRA), which is currently the Research and Policy Analysis Division (RPAD), the Statistical Analysis Center within the Office of Grants and Research (OGR), a division of the Massachusetts Executive Office of Public Safety and Security (EOPSS), in consultation with 344 Municipal Police Departments, 59

College/University Law Enforcement Agencies, 24 County Houses of Correction and Jails, 17 Massachusetts State Prisons, State Agencies with arrest powers or a lock-up facility in Massachusetts, and Emergency Medical Services (EMS), shall submit information regarding the delivery of emergency medical care to persons held in custody to the Massachusetts Attorney General.

(b) This legislation will require the Massachusetts Attorney General, in conjunction with the DCRA SAA, to annually acquire, collect, classify, and study the delivery of emergency medical care, and will require them to "report details in a uniform matter about when and how emergency medical care is summoned and provided."

(c) This annual report shall include information such as the frequency, nature, and timing of the delivery of such care, including but not limited to the number of emergency department admissions and hospitalizations along with limited data regarding the cause for the admission; the number of emergency medical services (EMS) activations, including the primary impression; and information regarding the emergency medical care provided to a person prior to a death in custody, along with other clinical data, if relevant or available, regarding the medical care provided prior to such a death.

(d) This report should include a section on psychiatric crises during arrest, including whether a 3-digit crisis report was made prior to law enforcement contact, and whether medical care was provided by emergency medical services (EMS), hospitalization or otherwise.

(e) For psychiatric crises involving medical personnel whose data is not integrated into the electronic medical record (EMR), such as under co-response models, this report is to create a uniform summary regarding critical incident responses and the medical care provided.

(f) Such data shall culminate in a yearly report regarding the delivery of emergency medical care to persons in custody, including a summary regarding the nature or primary impression associated with the medical need, the prevalence of such emergencies, and whether care was provided in a timely manner.