

State of Illinois

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2025 ILLINOIS DEATH IN CUSTODY ANNUAL REPORT



Illinois Criminal Justice Information Authority

2025 Illinois Death in Custody Annual Report

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Section 1: Background

Pursuant to the Illinois Reporting of Deaths in Custody Act (RDCA), the Illinois Criminal Justice Information Authority (ICJIA) is required to “issue a public annual report tabulating and evaluating trends and information on deaths in custody,” (730 ILCS 210/3-5(i)). The report is required to include: (1) demographic characteristics of persons who died in custody, (2) information on the circumstances surrounding deaths in custody, and (3) basic information about the justice system agencies involved in death in custody incidents (e.g., name, location). Additionally, ICJIA is required to provide “recommendations and state and local efforts underway to reduce deaths in custody” (730 ILCS 210/3-5(i)(3)).

In addition to RDCA, the federal Death in Custody Reporting Act (DCRA) also requires ICJIA to submit data on deaths in custody (34 U.S.C. § 60105). To comply with DCRA requirements, ICJIA submits quarterly information on deaths in custody to the Bureau of Justice Assistance (BJA). Reporting requirements under Illinois RDCA and federal DCRA are similar. Thus, ICJIA combines the two overlapping requirements into a single record collection and reporting process that satisfies both.

Reportable Incidents

Reportable incidents under federal-level DCRA include deaths:

- During the process of being detained or arrested.
- While under arrest or while being detained.
- While incarcerated in a state or municipal corrections facility (34 U.S.C. § 60105(a)).

Reportable incidents under state-level RDCA include deaths:

- While in custody of:
 - A law enforcement agency.
 - A state or local corrections facility.
 - A peace officer.
- As a result of a peace officer’s use of force (730 ILCS 210/3-5(b)).

There is significant overlap in reportable cases under each set of requirements. The primary difference is that RDCA explicitly requires reporting deaths due to a use of force.

The types of agencies required to report include:

- **Law enforcement agencies:** “Each law enforcement entity within this State having the authority to arrest and detain persons suspected of, or charged with, committing a criminal offense, and each law enforcement entity that operates a lock up, jail, prison, or any other facility used to detain persons for legitimate law enforcement purposes” (730 ILCS 210/3-5(a)).
- **Peace officers:** “Any person who by virtue of his office or public employment is vested by law with a duty to maintain public order or to make arrests for offenses... [or,] any person who, by statute, is granted and authorized to exercise powers similar to those conferred upon any peace officer employed by a law enforcement agency of this State” (720 ILCS 5/2-13).
- **Corrections:** “a state or local correctional facility” (730 ILCS 210/3-5(a)).

In practice, this means that ICJIA coordinates with police, sheriffs and jails, adult corrections, and juvenile justice to collect data on reportable incidents.

Data Sources

ICJIA collects death in custody data from several sources. Agencies may provide data through one or more of the following:

- **ICJIA Direct Reports:** On ICJIA’s death in custody webpage, agencies may click ICJIA’s direct reporting link to get to a Qualtrics survey (ICJIA, n.d.). The ICJIA survey includes all data fields required under both RDCA and DCRA.
- **Illinois State Police (ISP):** Under the Illinois Uniform Crime Reporting Act (UCR), ISP collects data on Arrest-Related Deaths (ARD) and Use of Force (UOF) incidents. These data are used in ICJIA’s death in custody reporting and quality assurance processes.
- **Illinois Department of Corrections (IDOC):** ICJIA receives data on deaths in adult corrections from the Planning and Research Division of IDOC.
- **Illinois Department of Corrections Jail and Detention Standards Unit (JDSU):** ICJIA receives data on deaths in county and municipal jails from the JDSU team at IDOC.
- **Illinois Department of Juvenile Justice (IDJJ):** IDJJ provides data on deaths that occur in any of its juvenile facilities.

In addition to data collection, ICJIA also engages in data quality assurance (See [Section 3](#)), using publicly available information to assess whether reportable cases are missing from the dataset. For these cases, ICJIA reaches out directly to the agency associated with each incident to solicit either a) a report or b) a rationale for why the case was not considered reportable.

This Report

The 2025 Illinois Death in Custody Annual Report includes the following sections:

Section 2: Summary - Deaths in Custody shows annual death in custody trends summarized over time by reporting agency and by decedent characteristics.

Section 3: Data Quality Control presents procedures and results from ICJIA's first full year of quality assurance for the death in custody dataset, which aims to improve data completeness and accuracy.

Section 4: Scoping Review of Literature on Reducing Deaths in Adult Corrections details a project currently underway to review academic and professional articles about efforts to prevent deaths in adult corrections.

Section 5: Stakeholder Interviews on Efforts to Reduce Deaths in Adult Corrections describes progress on a project that interviews stakeholders knowledgeable about existing efforts to reduce mortality in Illinois corrections.

Section 6: Conclusion reviews key findings, reiterates improvements to the RDCA dataset, and reviews progress made on RDCA-related projects in 2025.

Section 2: Summary - Deaths in Custody

This section summarizes demographic characteristics of individuals who died in custody (decedents) as well as agency-level and incident-level characteristics. Demographic characteristics presented include age at death, gender, and race/ethnicity. Agency characteristics presented include agency type and location. Incident characteristics presented include manner of death (a category based on circumstances of death) and type of location where death occurred. This is the fifth year that data are available, so most tables and figures present data from 2021 to 2025. A few focus only on calendar year 2025.

In 2025, a total of 170 deaths in custody were reported in Illinois. *Table 1* summarizes decedent demographics, agency characteristics, and incident characteristics from 2021 to 2025. Age and gender distribution have remained relatively consistent over time. 2025 was a relative high point for the proportion of decedents who were Hispanic or Latino, though most decedents were Black or White. The proportion of deaths in jails compared with post-conviction corrections settings has fluctuated over time, but deaths in corrections settings were consistently the most common. Manner of death has also seen some fluctuations. Most notably, a spike in deaths related to natural causes occurred in 2021. Deaths attributed to natural causes can include preventable medical events.

Factors that may have contributed to a higher total death count for 2025 include improvements in reporting compliance, quality assurance activities, or a higher incidence of deaths. Year-to-year comparisons should be interpreted with caution. Regardless of contributing factors, the total of 170 deaths represents a substantial loss of life among individuals in state custody.

Table 1*Illinois Deaths in Custody Reported to ICJIA, 2021-2025*

Field	n (% of Field Total)				
	2021	2022	2023	2024	2025
Decedent age					
20 or younger	1 (0.7%)	1 (0.8%)	2 (1.5%)	2 (1.5%)	4 (2.4%)
21-25	5 (3.4%)	8 (6.4%)	8 (5.9%)	5 (3.8%)	9 (5.3%)
26-35	9 (6.1%)	19 (15.2%)	22 (16.2%)	16 (12.2%)	15 (8.8%)
36-45	17 (11.5%)	13 (10.4%)	30 (22.1%)	24 (18.3%)	35 (20.6%)
46-55	23 (15.5%)	27 (21.6%)	23 (16.9%)	24 (18.3%)	29 (17.1%)
56-65	40 (27.0%)	29 (23.2%)	21 (15.4%)	26 (19.8%)	34 (20.0%)
66-79	43 (29.1%)	24 (19.2%)	23 (16.9%)	27 (20.6%)	39 (22.9%)
80 or older	8 (5.4%)	3 (2.4%)	7 (5.1%)	7 (5.3%)	5 (2.9%)
Missing	2 (1.4%)	1 (0.8%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	148	125	136	131	170
Decedent gender					
Male	142 (95.9%)	116 (92.8%)	127 (93.4%)	129 (98.5%)	166 (97.6%)
Female	6 (4.1%)	8 (6.4%)	9 (6.6%)	2 (1.5%)	4 (2.4%)
Missing	0 (0.0%)	1 (0.8%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	148	125	136	131	170
Decedent race/ethnicity					
Asian	2 (1.4%)	3 (2.4%)	0 (0.0%)	0 (0.0%)	1 (0.6%)
Black	78 (52.7%)	56 (44.8%)	53 (39.0%)	66 (50.4%)	73 (42.9%)
Hispanic/Latino	12 (8.1%)	13 (10.4%)	9 (6.6%)	13 (9.9%)	23 (13.5%)
White	56 (37.8%)	50 (40.0%)	68 (50.0%)	51 (38.9%)	72 (42.4%)
Missing	0 (0.0%)	3 (2.4%)	6 (4.4%)	1 (0.8%)	1 (0.6%)
Total	148	125	136	131	170

Field	2021	2022	2023	2024	2025
Type of location where event causing death occurred					
At arrest scene/while affecting an arrest	9 (6.1%)	12 (9.6%)	4 (2.9%)	9 (6.9%)	14 (8.2%)
Medical facility	1 (0.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.6%)
En route to a medical facility	0 (0.0%)	1 (0.8%)	1 (0.7%)	0 (0.0%)	0 (0.0%)
Booking center	0 (0.0%)	1 (0.8%)	0 (0.0%)	0 (0.0%)	1 (0.6%)
Municipal or county jail	11 (7.4%)	27 (21.6%)	39 (28.7%)	18 (13.7%)	25 (14.7%)
State prison	125 (84.5%)	76 (60.8%)	81 (59.6%)	95 (72.5%)	123 (72.4%)
Temporary holding facility	1 (0.7%)	2 (1.6%)	3 (2.2%)	1 (0.8%)	1 (0.6%)
Other	1 (0.7%)	6 (4.8%)	8 (5.8%)	8 (6.1%)	5 (3.0%)
Total	148	125	136	131	170
Manner of death					
Death attributed to use of force by a peace officer	8 (5.4%)	9 (7.2%)	9 (6.6%)	10 (7.6%)	12 (7.1%)
Homicide	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Natural causes	119 (80.4%)	64 (51.2%)	69 (50.7%)	75 (57.3%)	73 (42.9%)
Suicide	6 (4.1%)	19 (15.2%)	15 (11.0%)	16 (12.2%)	18 (10.6%)
Accident	6 (4.1%)	6 (4.8%)	3 (2.2%)	12 (9.2%)	8 (4.7%)
Unavailable ^a	0 (0.0%)	15 (12.0%)	20 (14.7%)	1 (0.8%)	20 (11.8%)
Other	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Missing	9 (6.1%)	12 (9.6%)	20 (14.7%)	17 (13.0%)	39 (22.9%)
Total	148	125	136	131	170
Agency type					
Police department	11 (7.4%)	18 (14.4%)	13 (9.6%)	11 (8.4%)	14 (8.2%)
Sheriff's office	12 (8.1%)	30 (24.0%)	41 (30.1%)	21 (16.0%)	20 (11.8%)
State corrections	125 (84.5%)	76 (60.8%)	82 (60.3%)	98 (74.8%)	123 (72.4%)
Missing	0 (0.0%)	1 (0.8%)	0 (0.0%)	1 (0.8%)	13 (7.6%)
Total	148	125	136	131	170

Note: Percentages may not equal 100%, due to rounding. Differences between the totals shown in *Table 1* and those in previous publications on death in custody data are due to ICJIA data quality checks.

^a Manner of death was listed as unavailable in cases pending investigation.

Figure 1 shows the total number of deaths in custody for each month of 2025. January had the highest number of deaths (24), while February, June, July, and September had the fewest (11 each). On average, 14 deaths a month occurred in custody.

Figure 1
2025 Deaths in Custody by Month (N = 170)

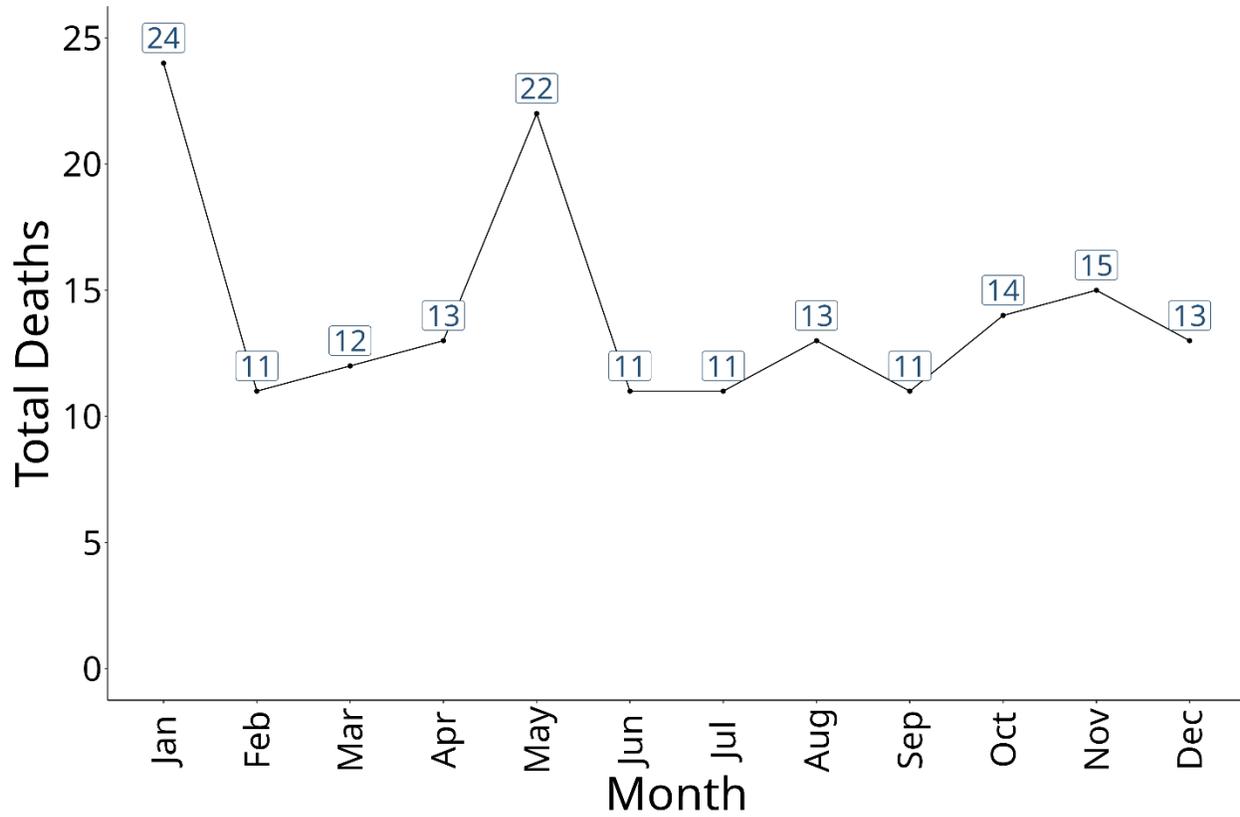


Figure 2a shows death in custody counts based on the location of the reporting agency from 2021 to 2025. Higher counts may reflect a higher population, rather than a higher relative risk of death in a given county. Cook County reported the highest number of deaths in 2025. Counties shaded grey did not report any deaths in custody from 2021 to 2025. *Figure 2b* shows deaths reported by sheriffs' departments in each county. *Figure 2c* shows deaths reported by police agencies in each county. *Figure 2d* shows deaths reported by correctional centers in each county. Each correctional center is labeled in *Figures 2a* and *2d*. Yellow labels indicate correctional centers that are currently being rebuilt.¹ Disaggregating the county-level data by agency type shows that death reports appear evenly spread throughout the state based on correctional center locations, but deaths reported by police and sheriffs tend to be concentrated in more populated areas.

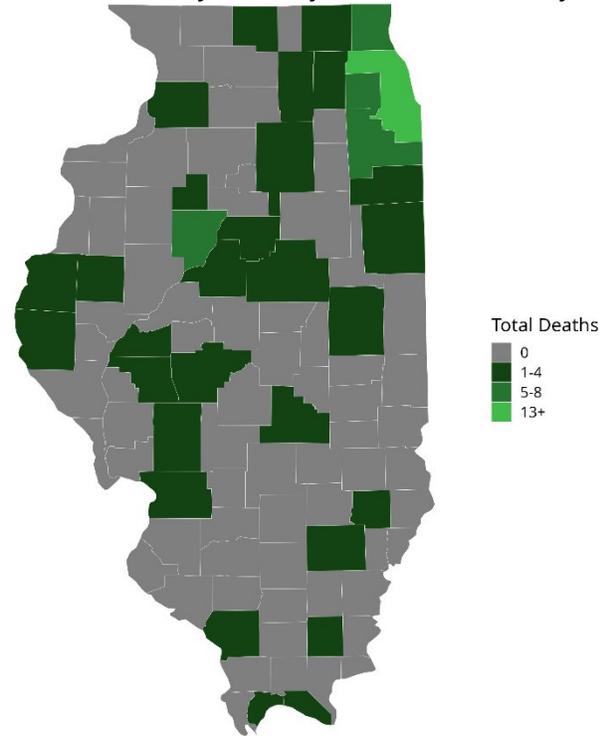
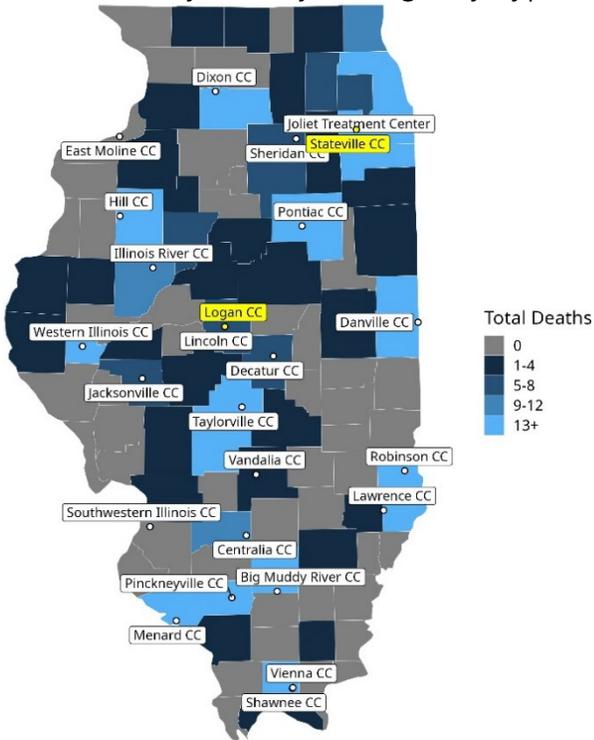
¹ *IDOC states that individuals in custody in Stateville will be transferred during the rebuild, and some individuals in Logan may be transferred on a case-by-case basis (IDOC, n.d.). News reports indicate that not all inmates had been transferred from Stateville before calendar year 2025 began, and the facility continued to report deaths in custody for 2025 (Paddock, 2024, 2025).*

Figure 2

2021-2025 Deaths in Custody by County and Agency Type

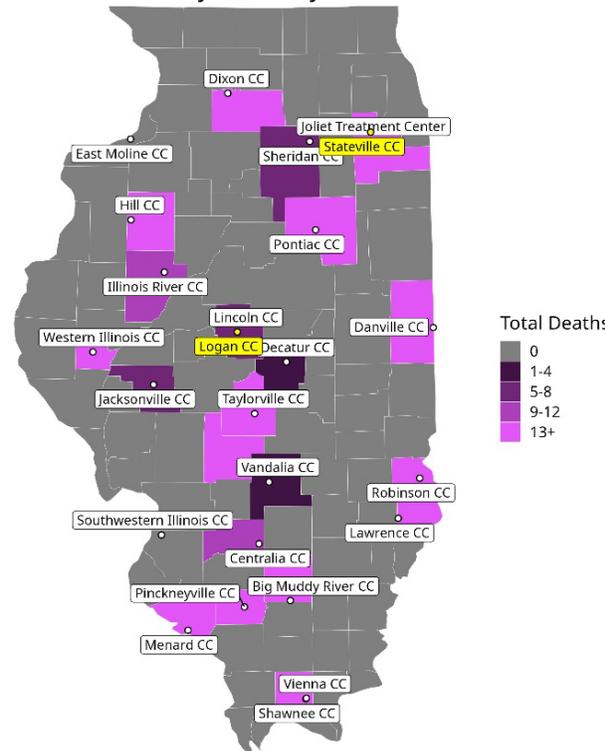
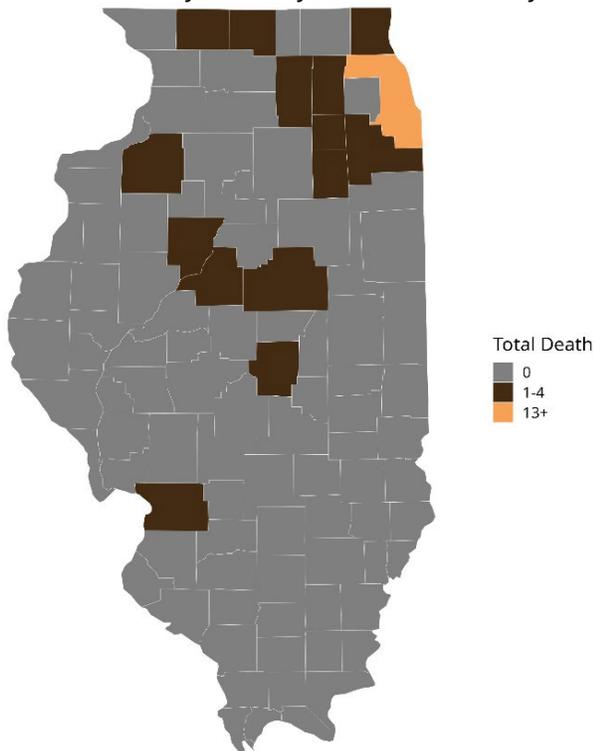
2a. Deaths by County, All Agency Types

2b. Deaths by County, Sheriffs Custody



2c. Deaths by County, Police Custody

2d. Deaths by County, Corrections Custody

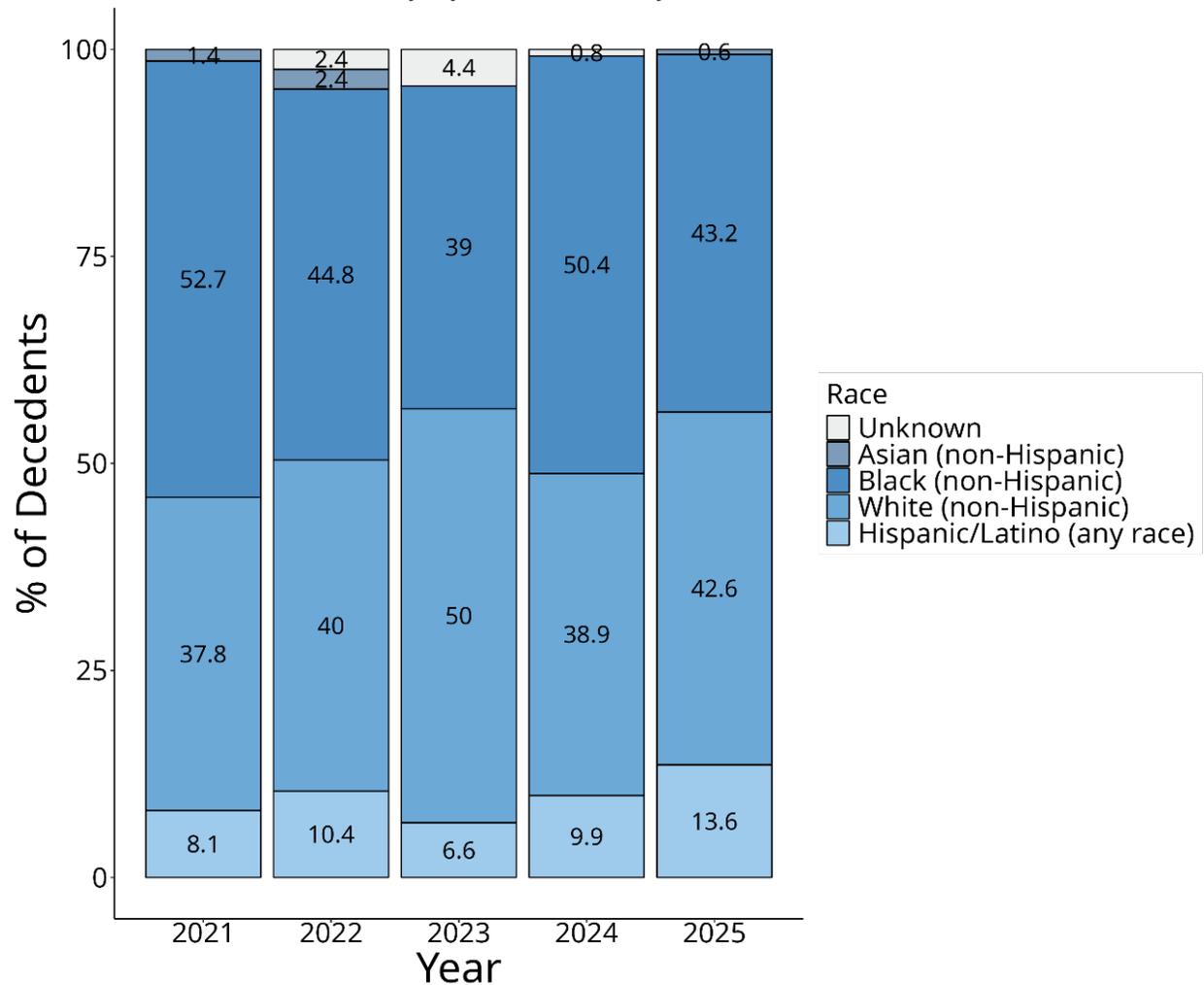


Demographics

Figure 3 presents percentages of decedents by race/ethnicity for 2021 to 2025. In 2025, most decedents were either Black (43.2%), or White (42.6%). The proportion of Hispanic/Latino decedents was slightly higher in 2025 than in previous years.² Less than 1% of decedents were Asian. When a decedent's race/ethnicity is marked as "Unknown," this means that the agency responsible for reporting the death in custody could not make a determination.

Figure 3

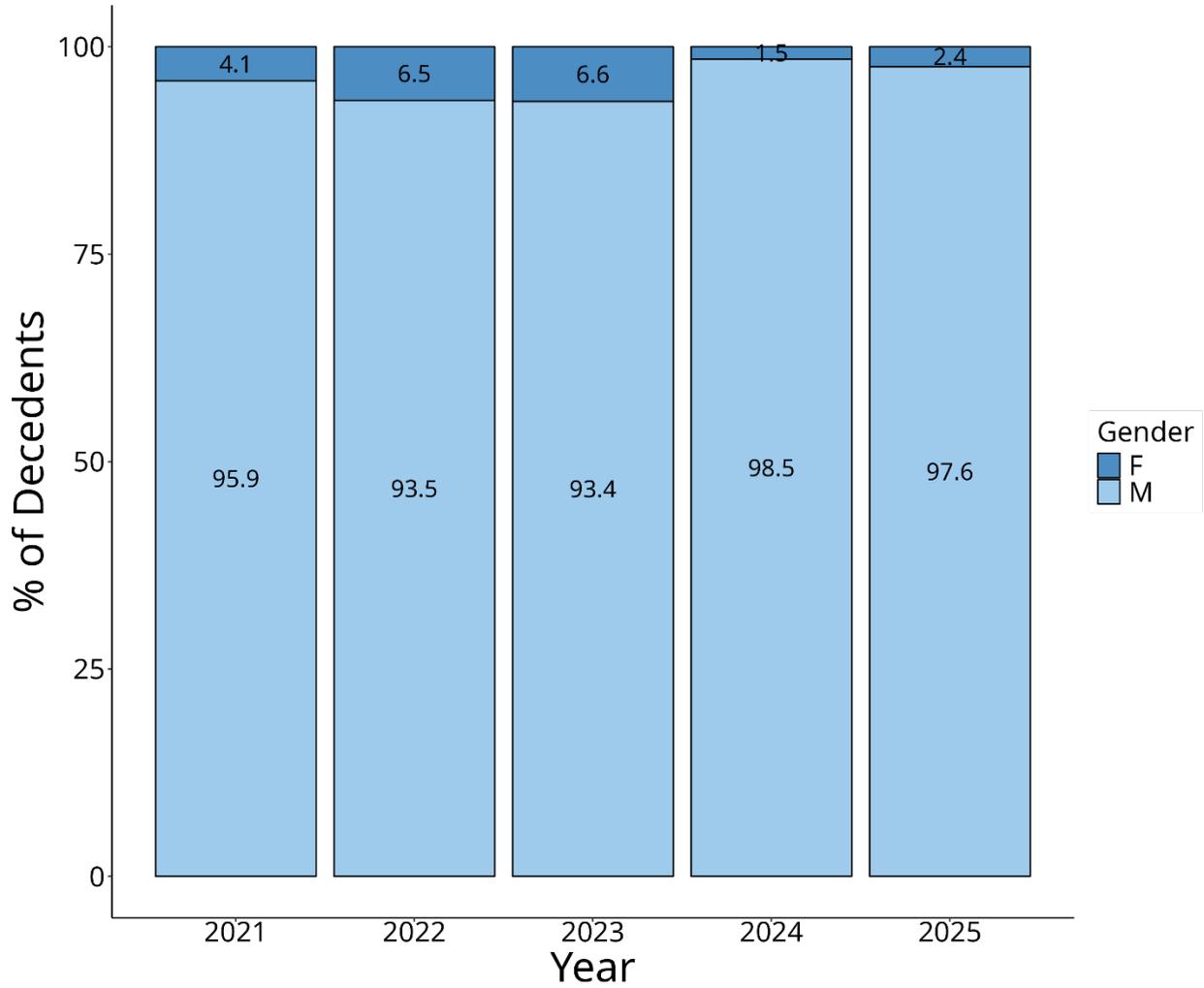
2021-2025 Deaths in Custody by Race/Ethnicity of Decedent (N = 169)



² In Figure 3, Hispanic/Latino ethnicity includes anyone who was identified as Hispanic/Latino, regardless of race. White, Black, and Asian racial identities include individuals who were marked as "not Hispanic/Latino," or whose ethnicity was unknown.

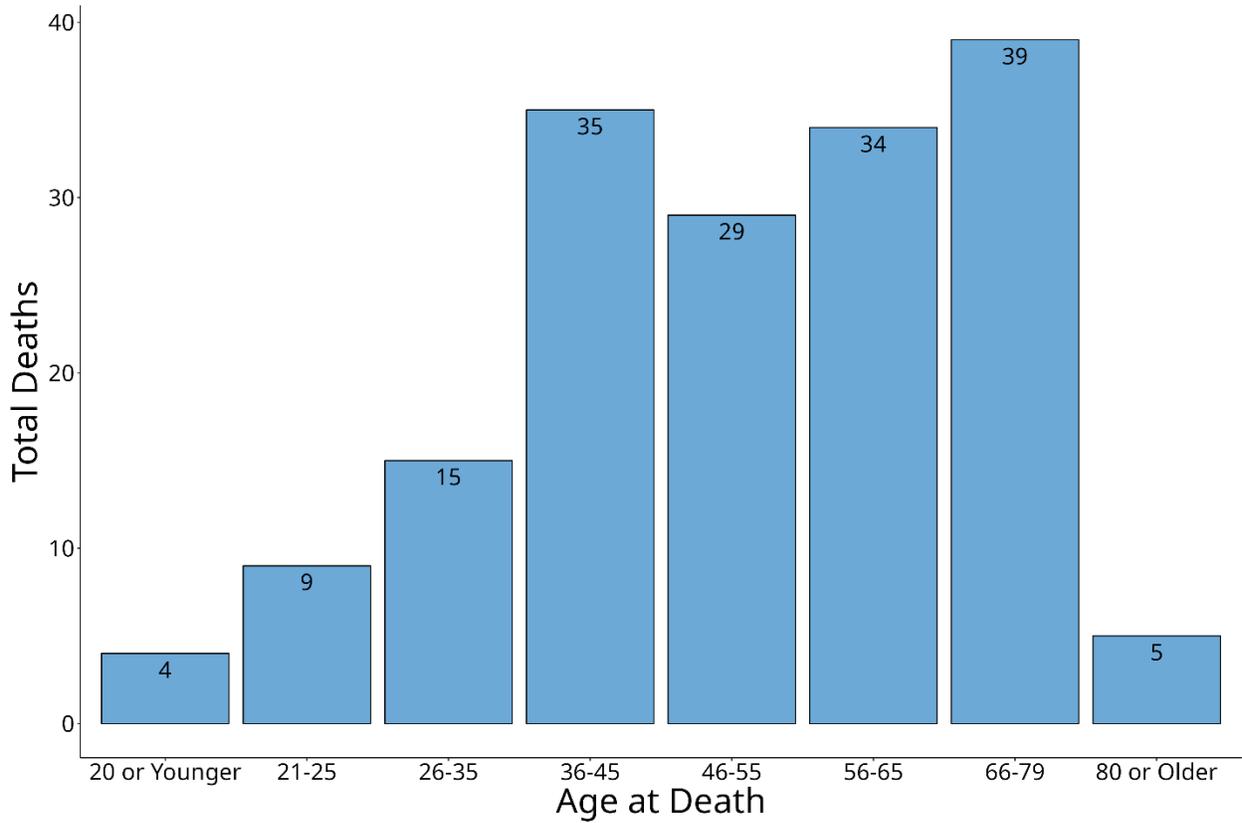
In 2025, 97.6% of decedents were identified as males and 2.4% as females. For each year from 2021 to 2025, over 90% of decedents were identified as male.

Figure 4
2021-2025 Deaths in Custody by Decedent Gender (N = 170)



In 2025, over one-third of decedents (37.1%) were 45 years old or younger. Roughly another third (37.1%) died between ages 46-65, and about one-quarter (25.8%) died at ages 66 or older.

Figure 5
2025 Deaths in Custody by Age at Death (N=170)



Agency Type

In 2025, as in previous years, most reports (78.3%) came from state corrections. Sheriff's offices (including jails operated by county sheriffs) accounted for 12.7% of reports, and police departments (including both state and local police) accounted for 8.9% of reports.

Figure 6
2021-2025 Deaths in Custody by Agency Type (N = 157)

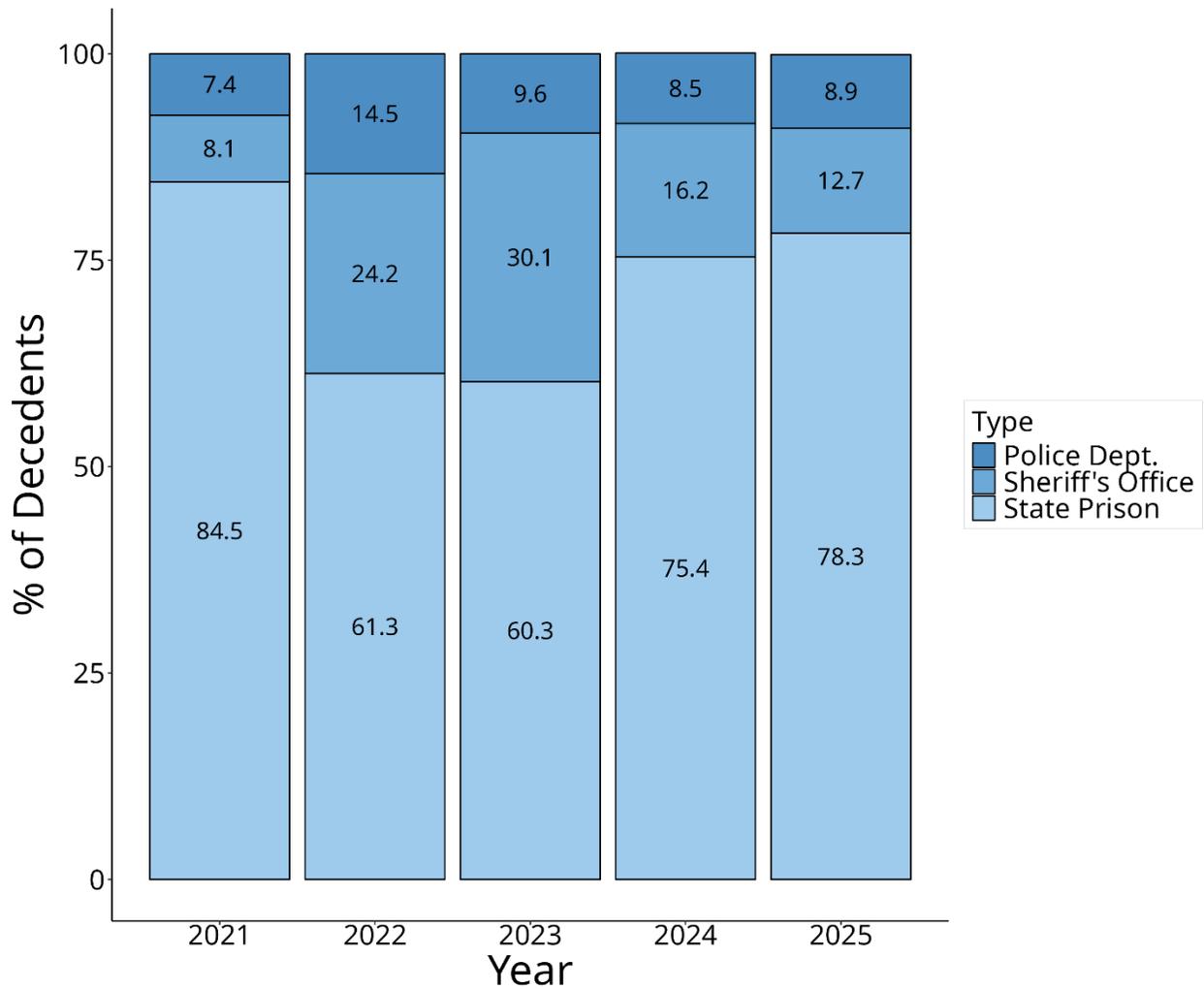


Figure 7 shows the average age of decedents by agency type for 2025 death in custody incidents. The average age at death was the youngest (39 years old) for deaths reported by police departments, and the oldest (56 years old) for deaths reported by state correctional centers. The overall average age of death in custody was 52 years old.

Figure 7
2025 Average Age at Death by Agency Type (N = 170)

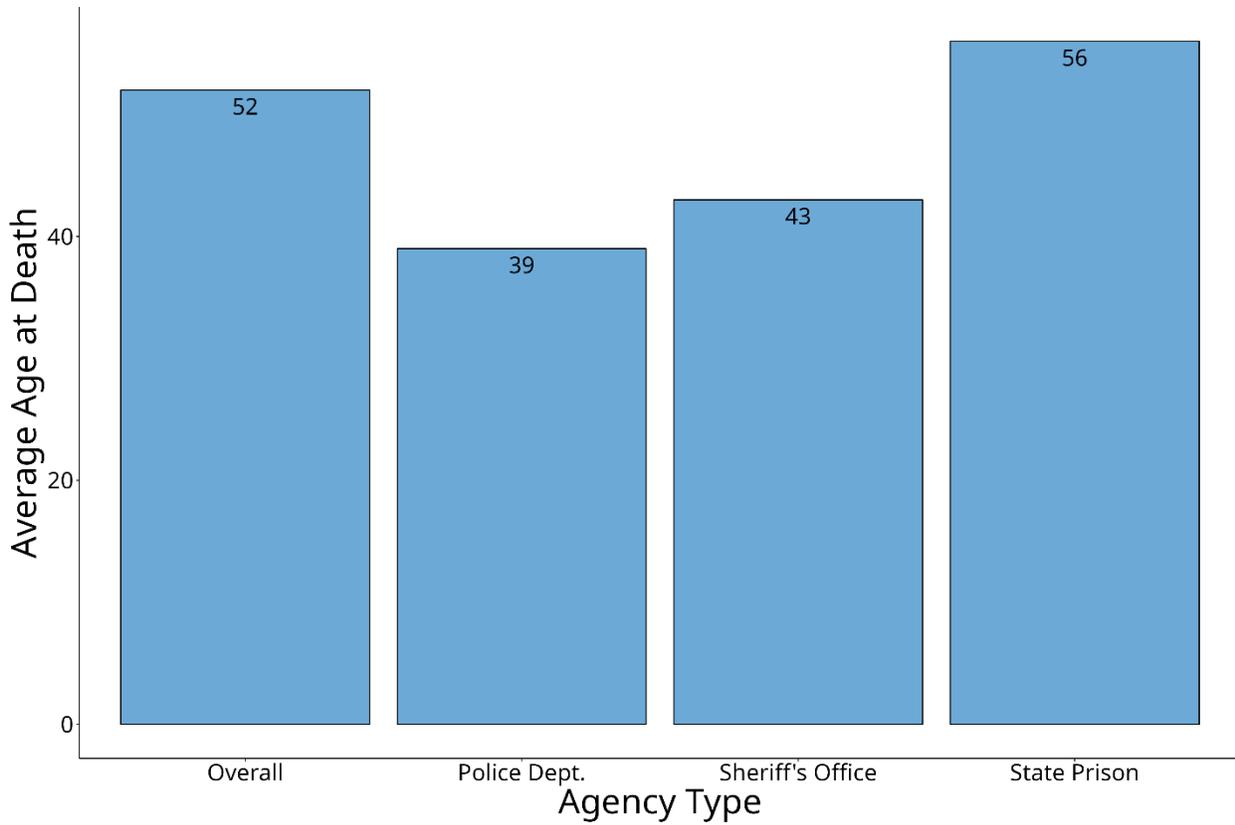
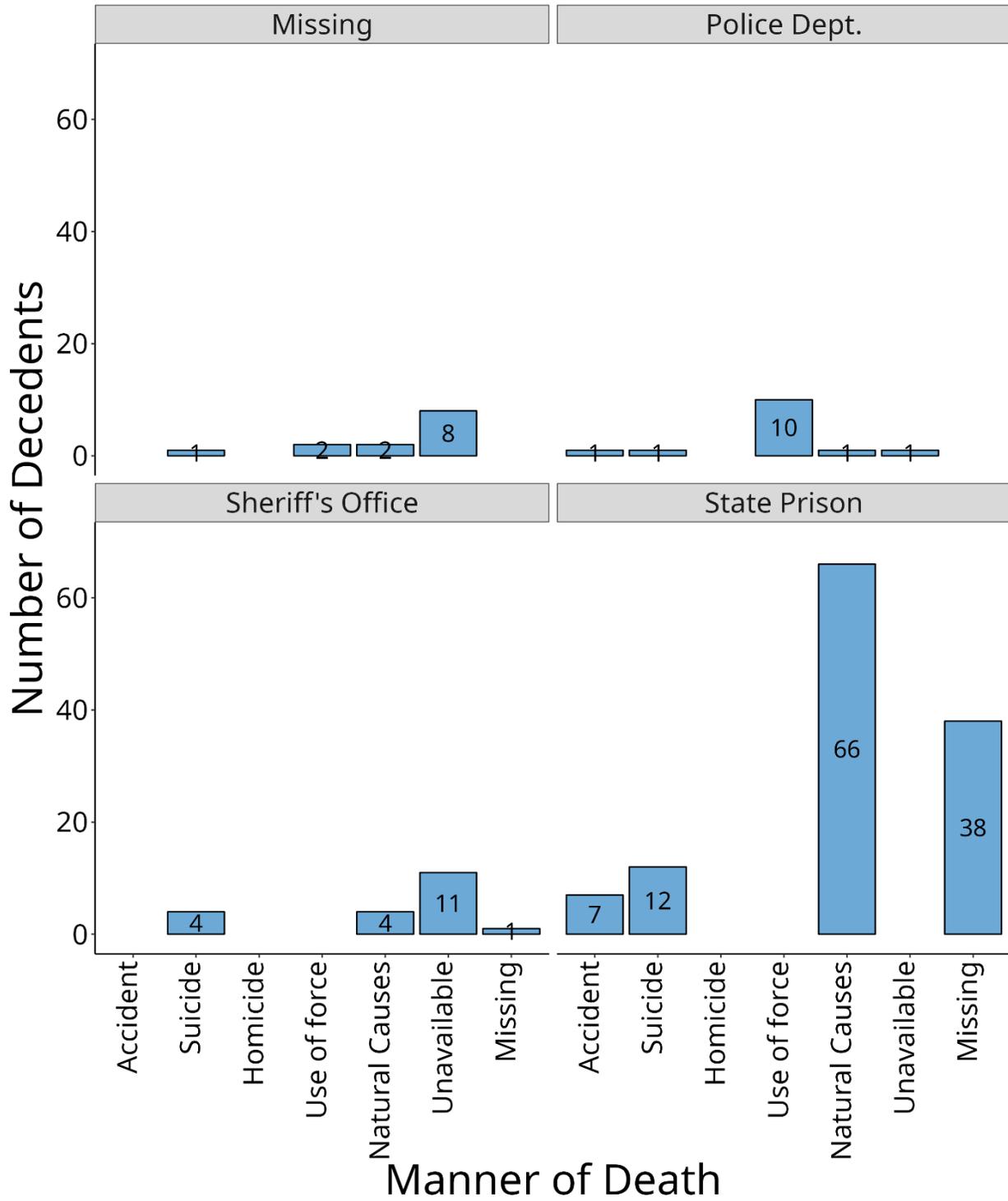


Figure 8 displays the manner of death by agency type. Manner of death classifies the circumstances surrounding a death into broad categories, typically including accident, suicide, homicide, natural causes, and undetermined (Hanzlick et al., 2002).³ In Illinois, the manner of death is often determined by the County Coroner (Centers for Disease Control and Prevention, 2024; Cook County Government, n.d.). For death in custody reporting, the manner of death may, in some instances, be provisional determinations made by reporting staff, such as correctional officers, law enforcement, medical personnel, or other criminal justice personnel. Comparisons across agency types should be interpreted with caution because provisional determinations may reflect differences in reporting practices.

The leading manner of death in police custody was use of force (10). In sheriff's custody, most cases from this year remain pending the results of an investigation (11 "Unavailable"). In corrections settings, the most common manner of death was natural causes (66). No homicides were reported by any agency type in 2025. A substantial share of deaths in custody in 2025 were recorded with a manner of death listed as unavailable or pending investigation, which limits definitive interpretation of the distribution of manners of death for this reporting year.

³ *In most circumstances where cause of death is related to overdose or unintentional toxicity, manner of death is classified as "accident." For the purposes of manner of death classification, natural causes can be almost any medical event that was not caused by human intervention, but many deaths by natural causes may be medically preventable (Hanzlick et al., 2002).*

Figure 8
 2025 Manner of Death by Agency Type (N = 170)



Summary - Death in Custody Totals

This section provided an overview of deaths in custody for 2025, including decedent demographics, agency characteristics, and circumstances of death, along with visualizations. Key findings include:

- There were 170 deaths in custody reported for 2025, which is the highest total in the past 5 years. The higher total may be due to a higher prevalence of deaths in custody, improved reporting compliance, enhanced data quality assurance processes, or a combination of factors. As a result, year-to-year differences in reported deaths should be interpreted cautiously.
- Based on monthly counts, no clear seasonal pattern was evident in 2025 deaths in custody.
- Deaths in IDOC custody did not appear to have much relationship to geography or population density of the surrounding area, whereas deaths in sheriffs' and police custody did. This finding is consistent with the nature of the law enforcement activities conducted by each agency type.
- There was a slight decrease in the proportion of decedents who were Black, and a slight increase in the proportion who were White, Hispanic/Latino, or Asian.
- The proportion of decedents who were male remained high.
- Ages at death remained young (52 years old on average) relative to the nonincarcerated population, highlighting the importance of understanding health and safety risks in custodial settings (National Center for Health Statistics, 2025).
- As in previous years, most deaths occurred in corrections custody (123), followed by sheriffs' custody (20), and then police custody (14).

Section 3: Data Quality Control

Previous Illinois death in custody annual reports described initial efforts to improve the quality and completeness of Illinois death in custody records. 2025 was the first full calendar year of implementation for ICJIA's improved data quality assurance process. This section describes quality assurance steps and provides summary statistics on data completeness and outreach activities.

The 2024 Illinois Deaths in Custody Annual Report described a quality assurance process that included quarterly follow-up contacts with agencies to ensure records were complete and accurate. The quality assurance steps implemented in 2024-2025 were designed to address:

- **Missing Fields:** Filling in missing information that was unknown or unavailable at the original time of reporting.
- **Missing Records:** Checking publicly available records to see if there were any unreported cases that seemed to fit the RDCA &/or DCRA definition.
- **Data Accuracy:** Cleaning the internal dataset to identify duplicates, typos, or other inaccuracies.

Identifying Missing Data

Each quarter, ICJIA reviews three months of data and flags any missing fields that are required. Manner of death is a field that often requires follow-up, because many agencies submit an initial death in custody report before a death investigation is complete. Other fields may be missing due to differences in reporting forms, and still others may contain information that is not available when the report is initially completed. During this data processing phase, duplicates, typos, or contradictory data fields may also be identified. When inaccuracies are identified, it is ICJIA's policy to reach out to the reporting agency for clarity rather than making inferences about intent.

ICJIA also works to identify any reportable cases that have not yet been received. Staff use such data sources as the Campaign Zero dataset, lethal use of force records from the Illinois State Police public website, and media reports identified through targeted keyword searches and date filters. Cases are reviewed and compared with RDCA and DCRA standards. When there is ambiguity regarding whether a case is reportable, it is included in outreach. Agencies may explain why a case was not considered reportable. The rationale is then documented, and the case is treated as resolved.

Juvenile justice is relatively unique among agency types, because deaths in juvenile justice custody are very rare. Due to infrequent occurrences, the reporting process

may result in periods of years without contact between ICJIA and juvenile justice agencies when there are no reportable incidents. From a data collection perspective, it can be difficult to differentiate between non-reporting and long periods of no incidents. To provide additional clarity, ICJIA has begun requesting a brief “zero report” from IDJJ, certifying that no deaths occurred during a specified period. Use of the zero report provides additional assurance that there were no deaths during a given period and facilitates consistent communication between ICJIA and our partners at IDJJ.

Outreach

Once missing records and missing or inaccurate fields have been identified, ICJIA staff begin the outreach process. Typically, updates from the previous quarter’s quality assurance get integrated into the dataset during the next quarter. If there is no update or resolution, agencies stay on the outreach list from quarter to quarter. Even with a quarterly cadence, some updates are not available for more than a calendar year. These are often instances in which the information remains unavailable to the reporting agency. For example, in order to be accurately completed, some data fields require results of a formal investigation. In some instances, the outreach process begins by contacting statewide partners (e.g., the Illinois Department of Corrections, which provides updates on all adult corrections records) to solicit current information. In other instances, individual reporting agencies are contacted (i.e., individual law enforcement agencies, with support from the Illinois State Police).

Summary Findings

Currently, ICJIA staff are completing the quality assurance process for records received from October through December 2025. The following is from one year of quality assurance, from October 2024 through September 2025:

Missing Fields

- 12 previously submitted records were missing data
- 6 received an update
- 1 resolved without an update (i.e., a clarification or rationale was provided)
- 5 remained unresolved

Missing Records

- 27 missing records were identified
- 8 received an update

- 6 resolved without an update
- 13 remained unresolved

Implications

Given that quality assurance is an ongoing process, there may be some changes between previous versions of any of ICJIA's death in custody data products and the most up-to-date versions. Efforts to improve the quality, completeness, and accuracy of the death in custody dataset are ongoing, and changes to the data reflect these efforts. Changes may include the addition of missing cases or fields, correction of errors, or removal of duplicates. In addition to improving the dataset, ICJIA has also improved its efforts to measure the success of outreach. In the future, these efforts may help identify areas where the outreach or reporting processes can be further improved.

Section 4: Scoping Review of Literature on Reducing Deaths in Adult Corrections

Background

The Reporting of Deaths in Custody Act (RDCA) requires ICJIA to include “recommendations... to reduce deaths in custody” in its annual report (730 ILCS 210/3-5(i)(3)). The question “How do we prevent deaths in custody?” is quite broad because contexts and causes of deaths in custody can vary significantly. For example, preventing overdose deaths in jails is quite different from preventing chronic illness deaths in adult corrections. In addition to the broad scope of the topic, the stakes are high. Given the wide scope and ethical implications of preventing deaths in custody, ICJIA has opted to develop multiple projects to generate targeted, evidence-informed recommendations.

The types of agencies expected to report deaths in custody include police, sheriffs/jails, adult corrections, and juvenile justice. To provide more relevant recommendations, ICJIA will conduct separate projects for each context. The first project will focus on reducing deaths in adult corrections, as this is the context where most deaths in custody occur each year. To date, the project team has developed a search and review strategy, conducted one academic database search, and begun evaluating results. Still to come, the team will screen publications for inclusion, collect data on the types of publications available, and review the full texts of included publications.

In the 2024 Illinois Deaths in Custody Annual Report, ICJIA committed to conducting a scoping review of literature as a first step towards making recommendations to reduce deaths in custody. A literature review is standard practice in many scientific disciplines for initiating the process of inquiry (Gottlieb, 2021; Mak & Thomas, 2022; Peters et al., 2021; Pollock et al., 2024). ICJIA elected to conduct a scoping review, which is often used as a starting point for assessing the state of evidence in a specific topic area. For the topic of reducing deaths in adult corrections, a scoping review of literature can help us understand:

- What kind of evidence is available on a topic.
- How evidence is being generated.
- What themes or patterns characterize prevention efforts.
- What we still need to know.

Findings from this scoping review will identify strengths and gaps in the existing evidence that can inform policy analysis. ICJIA will conduct future literature reviews on deaths in other contexts (i.e. police/sheriff's deputies, jails, and juvenile corrections).

Project Plan

Scoping reviews aim to provide an overview of the state of evidence on a specific subject. While they do not aim to analyze the quality of evidence or evaluate the effectiveness of specific interventions, they are often used to clarify what is known and unknown, identify the sources of knowledge, and note the patterns that characterize past interventions. The scoping review project will follow these steps:

- 1) Refine the central questions and keyword search strategy.
- 2) Create criteria for studies/articles/reports that will be included and excluded from the review during the screening process.
- 3) Train the review team and test the level of statistical agreement in their screening decisions.
- 4) Conduct a first round of screening papers to determine which to include in the review based on their titles and abstracts.
- 5) Conduct a next round of screening papers to determine which to include in the review based on the full text.
- 6) Re-read included papers and identify themes and key takeaways.
- 7) Write up the results (Levac et al., 2010; Mak & Thomas, 2022; Peters et al., 2015, 2021; Tricco, 2018).

ICJIA project staff include one analyst and one master's-level intern. Staff are currently engaged in step three. The initial search strategy involved collaborating with a university librarian with specialized knowledge of academic databases and their search engines (Mak & Thomas, 2022; Peters et al., 2021; Pollock et al., 2024). The team selected two databases to conduct the searches: Web of Science, which includes a broad range of academic papers, and Policy Commons, which also includes some "grey literature" such as reports and evaluations from government agencies, non-profits, and NGOs. The keyword search strategy identified four components to the topic of interest: a population of adults, a post-conviction incarceration setting, death as an outcome, and interventions focused on prevention or risk reduction. For each component, we generated 10-15 keywords. The team then conducted sample searches to assess the relevance of the results produced by this strategy and refined search terms and filters based on their assessments.

The team also developed inclusion and exclusion criteria for the screening process. Inclusion criteria are a set of characteristics that must be met by all included studies (Mak & Thomas, 2022; Peters et al., 2020; Pollock et al., 2024). Exclusion criteria are characteristics that automatically exclude a study from the review. For example, studies must include adults in the population of interest. On the other hand, any study that focuses solely on pretrial detention will be excluded, as our focus is on post-conviction corrections. Inclusion and exclusion criteria may be modified slightly during the early phases of review. Next, the team will upload the results of their searches to Covidence, software designed to streamline the publication screening process. Reviewers will screen 5-10% of the total, and once there is 90% agreement between them, the review can begin (Mak & Thomas, 2022). There will be two main rounds of review, one that uses the title and abstract to screen papers, and the next that screens based on the full text. This practice helps keep the review timeline realistic. If papers lack sufficient information in the title and abstract to determine their relevance, they will be moved to the next round for full-text review.

Once the review has produced a final sample of studies to be included in analysis, the team will read the studies in full and identify themes. In scoping reviews, themes are typically high-level, such as study design, population of interest, intervention model, stakeholders involved, and outcomes measured (Mak & Thomas, 2022). This study will not include a meta-analysis as a systematic review of literature would, so it will not evaluate the quality of the evidence or identify preferred interventions based on the data (Munn et al., 2018). Instead, the results and analysis will focus on areas where we have more or less evidence available, on themes in study design or intervention models, and on additional questions prompted by the existing research.

Initial Findings

A search in Web of Science returned 17,953 results. These results were filtered to include only articles available in English, published between 1975 and 2025. Over half of the results of this search (55.6%) were published in the last ten years, and nearly one-third (32.4%) were published in the last five years. About two in five studies (40.8%) were based in the United States. The next most common location for studies in this sample was the UK (12.5%), followed by Germany, Italy, and China (5.3%, 5.1%, and 5.0%, respectively).

To provide an overview of the search results, staff created a spreadsheet listing titles and abstracts (short summaries at the beginning of most academic publications) and searched for keywords relevant to our research questions. In some instances, search results paralleled key characteristics of Illinois death in custody records. For example, in 2025, the most common manner of death in adult corrections settings was natural causes. Accordingly, this search yielded a large number of articles on deaths from

natural causes. Some of the most common topics referenced in this body of literature were cancer (1132 results), diabetes (777 results), hypertension (725 results), HIV (622 results), stroke (512 results), and myocardial infarction (heart attack; 500 results). Covid-19 is frequently mentioned in death in custody reports for Illinois adult corrections. In line with these reports, this literature search returned 270 results related to Covid-19.

Suicide is another leading manner of death in adult corrections. The literature search returned 702 results that mentioned suicide. Other manners of death collected by ICJIA include homicide (294 results) and accidents (265 results). ICJIA's dataset does not differentiate unintentional overdoses from other categories of accidental deaths, but the literature search returned 406 results mentioning overdose. Use of force is a less common manner of death in adult corrections compared to other settings (sheriffs, police), and the literature search returned only 4 results mentioning use of force. Cohort studies were the most common study design mentioned in the abstracts returned by this search (777 results). Other common approaches included cross-sectional studies (274 results), case-control studies (262 results), qualitative studies (262 results), systematic reviews (211 results), meta-analyses (213 results), and randomized controlled trials (170 results).

A representative article that will likely be included in the full-text review stage is "Differences Between Inmates Who Attempt Suicide and Who Die by Suicide: Staff-Identified Psychological and Treatment-Related Risk Factors" by Folk et al. (2018). This study included 925 individuals, including adults incarcerated in state facilities, and the outcome of interest is related to mortality, which makes it eligible for inclusion. The study design is a retrospective cohort study, which means individuals who had attempted or died by suicide were identified, and then staff looked back at their medical records to identify potential risk factors. The study focused on treatment-related risk factors using data collected by mental health staff within corrections systems, which will likely prove relevant to our primary question regarding what the research says about how to prevent deaths within adult corrections.

A search using the same keywords and filters in Policy Commons returned over 600,000 results. Given the size of the project team (one full-time and one part-time staff member), the search strategy for Policy Commons will need to be refined to produce more targeted results in a lower volume that is realistic for a team of this size to review.

Section 5: Stakeholder Interviews on Efforts to Reduce Deaths in Adult Corrections

Background

The Illinois Reporting of Death in Custody Act (RDCA) requires ICJIA to include information on “State and local efforts underway to reduce deaths in custody” as part of its annual report on deaths in custody (730 ILCS 210/3-5(i)(3)). This goal encompasses deaths that occur across multiple agency types such as police, sheriffs/jails, adult corrections, and juvenile corrections. Conditions of custody, risk factors for death, and efforts to reduce deaths are likely to vary between these different settings, so ICJIA plans to design separate projects to address efforts to reduce deaths in each of these contexts. Most deaths in custody take place in adult corrections, so our first project focusing on efforts to reduce deaths in custody will focus on interviewing stakeholders with knowledge about the adult corrections system in Illinois.

The 2024 Illinois Death in Custody Annual Report included an overview of a stakeholder interview project. Qualitative research such as the interview approach we are using can capture nuanced ideas and allow themes to emerge from conversations. To date, staff have developed interview questions, identified stakeholders of interest, and conducted an interview with two stakeholders.

Project Plan

This project is the first step in fulfilling the requirement to report on efforts to reduce deaths in custody by interviewing key stakeholders about efforts underway to reduce deaths in adult corrections. The project includes the following steps:

- 1) Develop an interview guide.
- 2) Conduct a stakeholder analysis to document who is involved in efforts to reduce deaths in adult corrections.
- 3) Based on results of the stakeholder analysis, invite different types of stakeholders to participate in interviews.
- 4) Conduct interviews.
- 5) Analyze interviews for themes and main ideas.
- 6) Write up findings.

Step one is complete. Steps two through four are currently underway and are expected to overlap in timing. Project staff includes one ICJIA analyst and one master’s-level intern. Staff have developed a “semi-structured” interview guide, which means that the conversations begin with a set of main questions, and additional

prompts are used to learn more details as needed. The interview guide consists of 7 demographic questions, five main questions, and 13 probes, or optional follow-up questions. Main questions include:

- Please summarize any efforts you are aware of to reduce the number of deaths in adult corrections in Illinois.
- Please describe the history of [effort] up until today.
- How is [organization] evaluating success?
- What accomplishments have been made to date?
- What should the state of Illinois do to further reduce deaths in adult corrections in the future?

Semi-structured interviews allow for a natural conversation while ensuring that the most important topics are addressed. The stakeholder analysis is a visual tool, usually a chart or table, that will help ICJIA document the perceived landscape of stakeholders, and highlight efforts to represent as many viewpoints as possible (Lelea et al., 2014; Varvasovszsky & Brugha, 2000). The team aims to conduct 10-15 stakeholder interviews in the first round and may continue recruiting as needed. The project will use a snowball sampling method, which means that stakeholders will have the opportunity to suggest other potential participants to contact. This will allow staff to seek feedback on any gaps in the recruitment strategy, and to continue recruiting until new themes do not come up in interviews.

The point in a qualitative interview project at which no new themes emerge is termed “thematic saturation,” and this will be the threshold for ending the interview phase (Hennink et al., 2016). Interviews will be conducted via WebEx video conferencing software, and with consent, recorded and transcribed. Transcripts will be uploaded into a qualitative analysis software such as NVivo or MaxQDA, and analyzed for key themes. Thematic analysis will be the primary qualitative coding approach. Compared to other qualitative analysis approaches, thematic analysis lets patterns emerge from interview responses rather than choosing a framework in advance and looking for those themes (MAXQDA, n.d.; Naeem et al., 2023). Then, we will write up a summary of main ideas with some quotes to illustrate, takeaways for the current state of efforts to reduce deaths in adult corrections, and possible future directions these efforts may take.

Initial Findings

The first two organizations invited to participate in interviews were IDOC and a nonprofit organization related to prison oversight and evaluation. ICJIA staff interviewed two participants, both employees of the nonprofit, over 60 minutes via

WebEx. No one from IDOC was available for interview in time for this publication. ICJIA will continue recruiting participants in 2026, aiming to represent a variety of perspectives on efforts taken to reduce deaths in IDOC custody.

Participants were invited to discuss strategies they or their organization had taken to reduce deaths in corrections, or strategies they were aware others had taken. Both participants had similar backgrounds: they had been with their organization for over 10 years, held leadership positions within it, and had experience in the legal field. We discussed efforts to reduce deaths in Illinois corrections dating back to over a decade ago. Initial themes that emerged from responses were strategies to prevent deaths in custody, key stakeholders, goals or outcomes they perceive, barriers or challenges that arise in their work, overarching advocacy strategies, and values that drive their work.

Prevention Strategies

Participants described prevention strategies focused on improvements to medical care within IDOC. Efforts to improve medical care included policy changes, such as statewide legislation abolishing medical copayments in IDOC and facility policies expanding coverage for preventive healthcare. Other medical care improvements include long-standing efforts to address capacity challenges, such as chronic understaffing within IDOC, and efforts to establish consistent medication schedules. Longer-term capacity building efforts discussed included creating new oversight mechanisms, including medical expertise. Efforts to increase access to timely care included raising awareness about the cost of delaying treatment and the prevalence of health risk factors within the incarcerated population. The transition of medical care providers within IDOC was identified as a significant change with potential implications that have yet to be observed.

Another theme in prevention was decarceration - in this case, options for early release or system-level changes that reduce the amount of exposure to harsh conditions of incarceration that can increase mortality risk. Topics that came up on the theme of decarceration were sentencing credits, shorter supervised release, closures of facilities with a history of health or safety issues and expanding the use of medical release.

Stakeholders

Another theme that emerged was stakeholder engagement. The participants named a wide range of stakeholders involved in efforts to reduce deaths in corrections. They both highlighted that incarcerated people are the most important stakeholders: "our major constituency, which is the—you know—almost 30,000 people who are in custody

have very little ability to be heard or share their perspectives, experiences, and views.” Participants’ emphasis on incarcerated people as primary stakeholders also highlighted a limitation: few opportunities for the most directly impacted people to share input alongside other stakeholders. Other stakeholders mentioned by participants included IDOC staff and administrators; friends, family, and communities of incarcerated people; legislators; state agencies; advocacy organizations; the media; attorneys; grant funders; medical experts; and researchers.

Outcomes

Multiple outcomes related to efforts to prevent deaths in custody were discussed. Some outcomes mentioned were directly related to mortality, and others were products of relevant work. One of the first outcomes mentioned by both participants was preventable deaths. Another outcome mentioned several times was overall safety and wellness. Mortality risk after release from incarceration also came up a few times. Outcomes related to prevention included access to hygiene supplies and vaccines. Harm reduction—reducing exposure to the health harms associated with incarceration—was a related goal. A more abstract outcome discussed was a sense of connectedness with incarcerated people, who often struggle to maintain connections to people outside.

Challenges

Efforts to reduce deaths in custody come with challenges. Participants mentioned challenges on a population level, such as the high prevalence of health vulnerabilities, mental illness, and substance use disorders in prison settings, and aging prison population accompanied by age-related health needs. Additional challenges were logistical: limited access to incarcerated people by nonprofit staff, limited staffing within IDOC, limited staffing within the participants’ workplaces, and funding limitations. Legal and political challenges were mentioned consistently by both participants, including administration changes in state agencies (including IDOC), complex Illinois procurement law, and navigating relationships with stakeholders who may have different positions on an issue. Information often posed challenges, including issues such as outdated information coming from large systems, and unverified information circulating rapidly in the community. Time challenges were also discussed, including the lag in time between data collection and publication when advocating for data transparency, and the long time horizon of advocacy work, while incarcerated people are impacted on a much shorter time scale.

Advocacy

Advocacy strategies were a main theme with participants. A wide array of advocacy strategies were mentioned. Data collection and transparency were among the most

frequently mentioned strategies, including discussion of diverse data collection strategies and emphasis on the importance of observational data. As one participant put it: "getting the information about a problem in order to craft solutions that are likely to be effective." Another theme was legal advocacy, encompassing litigation, legislation, and policy implementation. Managing stakeholder relationships was frequently mentioned, including relationships built through community outreach. Stakeholder management strategies included consistent messaging and efforts not to duplicate work. Relatedly, media strategy came up several times with both participants. Policy advocacy was the last major advocacy theme, which included discussion of lobbying, utilizing windows of opportunity, and building support via research.

Values

Finally, participants mentioned values that motivate their involvement in efforts to reduce deaths in prison. A value mentioned repeatedly by both participants was the involvement of individuals with personal experience of incarceration, including in organizational hiring. More abstract values included transparency, independence, and human rights.

Section 6: Conclusion

Calendar year 2025 was the first full year of implementation of ICJIA's improved quality assurance process with the death in custody dataset, representing an important foundation for future prevention-focused analyses. The data showed:

- 170 total deaths in custody were reported for 2025
- 12 cases were missing some data
 - 58% were updated or resolved during quality assurance, 42% unresolved
- 27 records were missing from the dataset
 - 48% were updated or resolved during quality assurance, 52% unresolved

Additionally, we began implementing two projects addressing the requirements to 1) produce recommendations to reduce deaths in custody and 2) describe efforts underway to reduce deaths in custody. These projects will focus on reducing deaths in adult corrections settings. A scoping review of the literature and a series of stakeholder interviews are planned for publication in 2026.

Key accomplishments from this year include: 1) establishing quality assurance procedures and points of contact; 2) tracking data on outreach activities and quality assurance findings; 3) planning and beginning a scoping review of literature on preventing deaths in adult corrections; and 4) planning and launching a stakeholder interview project on efforts to prevent deaths in adult corrections.

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