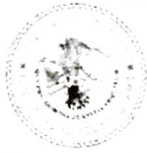


Form NPS-4A  
(Addendum)
**MORTALITY IN CORRECTIONAL INSTITUTIONS 2019  
STATE PRISON INMATE  
DEATH REPORT**

 U.S. DEPARTMENT OF JUSTICE  
BUREAU OF JUSTICE STATISTICS  
AND ACTING AS COLLECTION AGENT:  
RTI INTERNATIONAL
**FORM COMPLETED BY:**

Name	<input type="text"/>	Title	<input type="text"/>
Official Address	<input type="text"/>	Telephone	<input type="text"/>
City	<input type="text"/>	FAX	<input type="text"/>
State	<input type="text"/>	Zip	<input type="text"/>
		E-mail	<input type="text"/>

**Instructions for Completion**If no deaths occurred in 2019:

- You do not need to complete this form.

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- Make copies of this form for each additional death.
- Complete the entire form for each inmate death.
- Once your death records are complete, there are several ways to submit a death report:

**ONLINE:** Complete the report online at: <https://bjsmci.rti.org>
**E-MAIL:** [bjsmci@rti.org](mailto:bjsmci@rti.org)
**FAX (TOLL-FREE):** (866) 800-9179

**MAIL:** RTI International, Attn: Data Capture  
Project #: 0215015.001.300.117.102.100  
5265 Capital Boulevard  
Raleigh, NC 27690-1652

*If you need assistance, contact the data collection team at RTI International toll-free at (800) 344-1387 or [bjsmci@rti.org](mailto:bjsmci@rti.org)*
**What deaths should be reported?****INCLUDE** deaths of ALL persons...

- Confined in your correctional facilities, whether housed under your jurisdiction or that of another state
- Under your jurisdiction but housed in private correctional facilities, whether located in or out of state
- Under your jurisdiction but in special facilities (e.g., medical/treatment/release centers, halfway houses, police/court lockups, or work farms)
- In transit to or from your facilities while under your supervision

**EXCLUDE** deaths of ALL persons...

- Executed in your state
- Confined in local jail facilities, whether located in or out of state
- Under your jurisdiction but housed in a state-operated correctional facility in another state or in a federal facility
- Under probation or parole supervision in your state
- Under your jurisdiction but on AWOL or escape-status at the time of death

**BURDEN STATEMENT**

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# STATE PRISON INMATE DEATH REPORT

**1. What was the inmate's name?**

Armstrong Carlos V  
LAST FIRST MI

**2. On what date did the inmate die?**

1 2 0 3 2 0 1 9  
MONTH DAY YEAR

**3. What was the name and location of the correctional facility involved?**

Facility Name:

ELAYN HUNT CORRECTIONAL CENTER

Facility City:

SAINT GABRIEL

Facility State:

LA

**4. What was the inmate's date of birth?**

0 7 1 2 1 9 7 6  
MONTH DAY YEAR

**5. What was the inmate's sex?**

- ☒ Male  
☐ Female

**6. Was the inmate of Hispanic, Latino, or Spanish origin?**

- ☐ Yes  
☒ No

**7. In addition, what was the inmate's race? Please select one or more of the following racial categories:**

- ☐ White  
☒ Black or African American  
☐ American Indian or Alaska Native  
☐ Asian  
☐ Native Hawaiian or Pacific Islander  
☐ Some other race

→ Please Specify:

**8. On what date was the inmate admitted to one of your correctional facilities?**

1 0 3 0 1 9 9 8  
MONTH DAY YEAR

**9. For what offense(s) was the inmate being held?**

a. Second Degree Murder

b.

c.

d.

e.

**10. Since admission, did the inmate ever stay overnight in a mental health facility?**

- ☐ Yes  
☐ No  
☒ Don't Know

**11. Where did the inmate die?**

- ☐ In a general housing unit in the facility or in a general housing unit on prison grounds  
☐ In a segregation unit  
☐ In a special medical unit/infirmary within your facility  
☐ In a special mental health services unit within your facility  
☒ In a medical center outside your facility  
☐ In a mental health center outside your facility  
☐ While in transit  
☐ Elsewhere

→ Please Specify:



12. Are the results of a medical examiner's or coroner's evaluation (such as an autopsy, postmortem exam, or review of medical records) available to establish an official cause of death?

☐ YES → **CONTINUE TO Q13**

☐ Evaluation complete—results are pending

→ **SKIP REMAINING QUESTIONS AND SUBMIT THIS FORM—YOU WILL BE CONTACTED AT A LATER TIME FOR THE CAUSE OF DEATH**

☒ No evaluation is planned → **CONTINUE TO Q13**

13. What was the cause of death? \*\*\* Please SPECIFY cause of death—it is critical information\*\*\*

☐ Illness—Exclude AIDS-related deaths [Specify] →

☒ Acquired Immune Deficiency Syndrome (AIDS)

☐ Accidental alcohol/drug intoxication [Describe] →

☐ Accidental injury to self [Describe] →

☐ Accidental injury by other (e.g., vehicular accidents during transport) [Describe] →

☐ Suicide (e.g., hanging, knife/cutting instrument, intentional drug overdose) [Describe] →

☐ Homicide [Describe] →

☐ Other cause(s) [Specify] →

14. Where did the incident (e.g., accident, suicide, or homicide) causing the death take place?

☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

☐ In the prison facility or on the prison grounds

[PLEASE SPECIFY]

☐ In the inmate's cell/room

☐ In a temporary holding area/lockup

☐ In a common area within the facility (e.g., yard, library, cafeteria)

☐ In a special medical unit/infirmery

☐ In a special mental health services unit

☐ In a segregation unit

☐ On death row, special unit awaiting capital punishment

☐ Elsewhere within the prison facility

→ Please Specify:

☐ Outside the prison facility (e.g., while on work release or on work detail)

☐ Elsewhere

→ Please Specify:

15. When did the incident (e.g., accident, suicide, or homicide) causing the death occur?

☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

☐ Morning (6 am to Noon)

☐ Afternoon (Noon to 6 pm)

☐ Evening (6 pm to Midnight)

☐ Overnight (Midnight to 6 am)

16. Excluding emergency care provided at the time of death, did the inmate receive any of the following medical services for the medical condition that caused his/her death after admission to your correctional facilities?

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

	YES	NO	DON'T KNOW
a. Evaluated by physician/medical staff .....	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b. Diagnostic tests (e.g., X-rays, MRI) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c. Medications .....	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d. Treatment/care other than medications .....	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
e. Surgery .....	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
f. Confinement in special medical unit .....	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

**PLEASE PROVIDE A  
RESPONSE FOR  
EACH ITEM (a–f)**

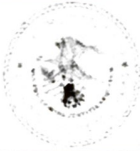
17. Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? (If multiple conditions caused the death and any of the conditions were pre-existing, mark "Pre-existing medical condition.")

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

- ☒ Pre-existing medical condition  
☐ Deceased developed condition after admission  
☐ Could not be determined

Please add any additional notes regarding this death here:



Form NPS-4A  
(Addendum)
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**STATE PRISON INMATE**  
**DEATH REPORT**

 U.S. DEPARTMENT OF JUSTICE  
 BUREAU OF JUSTICE STATISTICS  
 AND ACTING AS COLLECTION AGENT:  
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**FORM COMPLETED BY:**

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- In transit to or from your facilities while under your supervision

EXCLUDE deaths of ALL persons...

- Executed in your state
- Confined in local jail facilities, whether located in or out of state
- Under your jurisdiction but housed in a state-operated correctional facility in another state or in a federal facility
- Under probation or parole supervision in your state
- Under your jurisdiction but on AWOL or escape-status at the time of death

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# STATE PRISON INMATE DEATH REPORT

the results of medical evaluation  
☐ YES  
☐ NO  
☐ Evaluating

1. What was the inmate's name?

Artis Darrell D  
LAST FIRST MI

2. On what date did the inmate die?

1 2 1 6 2 0 1 9  
MONTH DAY YEAR

3. What was the name and location of the correctional facility involved?

Facility Name:  
 ELAYN HUNT CORRECTIONAL CENTER  
 Facility City: SAINT GABRIEL Facility State: LA

4. What was the inmate's date of birth?

1 2 1 4 1 9 5 6  
MONTH DAY YEAR

5. What was the inmate's sex?

- ☒ Male  
☐ Female

6. Was the inmate of Hispanic, Latino, or Spanish origin?

- ☐ Yes  
☒ No

7. In addition, what was the inmate's race? Please select one or more of the following racial categories:

- ☐ White  
☒ Black or African American  
☐ American Indian or Alaska Native  
☐ Asian  
☐ Native Hawaiian or Pacific Islander  
☐ Some other race

↳ Please Specify:

8. On what date was the inmate admitted to one of your correctional facilities?

0 1 1 6 1 9 9 2  
MONTH DAY YEAR

9. For what offense(s) was the inmate being held?

- a. Second Degree Murder  
 b.  
 c.  
 d.  
 e.

10. Since admission, did the inmate ever stay overnight in a mental health facility?

- ☐ Yes  
☐ No  
☒ Don't Know

11. Where did the inmate die?

- ☐ In a general housing unit in the facility or in a general housing unit on prison grounds  
☐ In a segregation unit  
☐ In a special medical unit/infirmery within your facility  
☐ In a special mental health services unit within your facility  
☒ In a medical center outside your facility  
☐ In a mental health center outside your facility  
☐ While in transit  
☐ Elsewhere

↳ Please Specify:



limited to one

the results of a medical examiner's or coroner's evaluation (such as an autopsy, postmortem exam, or view of medical records) available to establish an official cause of death?

☐ YES → **CONTINUE TO Q13**

☐ Evaluation complete—results are pending

→ **SKIP REMAINING QUESTIONS AND SUBMIT THIS FORM—YOU WILL BE CONTACTED AT A LATER TIME FOR THE CAUSE OF DEATH**

☒ No evaluation is planned → **CONTINUE TO Q13**

**13. What was the cause of death? \*\*\* Please SPECIFY cause of death—it is critical information\*\*\***

☒ Illness—Exclude AIDS-related deaths [Specify] → End Stage- Congestive Heart Failure

☐ Acquired Immune Deficiency Syndrome (AIDS)

☐ Accidental alcohol/drug intoxication [Describe] →

☐ Accidental injury to self [Describe] →

☐ Accidental injury by other (e.g., vehicular accidents during transport) [Describe] →

☐ Suicide (e.g., hanging, knife/cutting instrument, intentional drug overdose) [Describe] →

☐ Homicide [Describe] →

☐ Other cause(s) [Specify] →

**14. Where did the incident (e.g., accident, suicide, or homicide) causing the death take place?**

☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

☐ In the prison facility or on the prison grounds

[PLEASE SPECIFY]

☐ In the inmate's cell/room

☐ In a temporary holding area/lockup

☐ In a common area within the facility (e.g., yard, library, cafeteria)

☐ In a special medical unit/infirmery

☐ In a special mental health services unit

☐ In a segregation unit

☐ On death row, special unit awaiting capital punishment

☐ Elsewhere within the prison facility

→ Please Specify:

☐ Outside the prison facility (e.g., while on work release or on work detail)

☐ Elsewhere

→ Please Specify:

**15. When did the incident (e.g., accident, suicide, or homicide) causing the death occur?**

☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

☐ Morning (6 am to Noon)

☐ Afternoon (Noon to 6 pm)

☐ Evening (6 pm to Midnight)

☐ Overnight (Midnight to 6 am)

16. Excluding emergency care provided at the time of death, did the inmate receive any of the following medical services for the medical condition that caused his/her death after admission to your correctional facilities?

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

	YES	NO	DON'T KNOW
a. Evaluated by physician/medical staff .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnostic tests (e.g., X-rays, MRI) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c. Medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Treatment/care other than medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Surgery .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Confinement in special medical unit .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PLEASE PROVIDE A  
RESPONSE FOR  
EACH ITEM (a-f)**

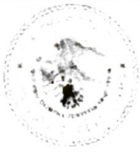
17. Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? (If multiple conditions caused the death and any of the conditions were pre-existing, mark "Pre-existing medical condition.")

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

- ☐ Pre-existing medical condition
- ☐ Deceased developed condition after admission
- ☒ Could not be determined

Please add any additional notes regarding this death here:



Form NPS-4A  
(Addendum)
**MORTALITY IN CORRECTIONAL INSTITUTIONS 2019**  
**STATE PRISON INMATE**  
**DEATH REPORT**

 U.S. DEPARTMENT OF JUSTICE  
 BUREAU OF JUSTICE STATISTICS  
 AND ACTING AS COLLECTION AGENT:  
 RTI INTERNATIONAL
**FORM COMPLETED BY:**

Name	<input type="text"/>	Title	<input type="text"/>
Official Address	<input type="text"/>	Telephone	<input type="text"/>
City	<input type="text"/>	FAX	<input type="text"/>
State	<input type="text"/>	Zip	<input type="text"/>
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EXCLUDE deaths of ALL persons...

- Executed in your state
- Confined in local jail facilities, whether located in or out of state
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# STATE PRISON INMATE DEATH REPORT

Are the re  
review of

1. What was the inmate's name?

Baughman Charles N  
LAST FIRST MI

2. On what date did the inmate die?

1 2 1 2 2 0 1 9  
MONTH DAY YEAR

3. What was the name and location of the correctional facility involved?

Facility Name:

ELAYN HUNT CORRECTIONAL CENTER

Facility City:

SAINT GABRIEL

Facility State:

LA

4. What was the inmate's date of birth?

0 3 0 1 1 9 6 3  
MONTH DAY YEAR

5. What was the inmate's sex?

- ☒ Male  
☐ Female

6. Was the inmate of Hispanic, Latino, or Spanish origin?

- ☐ Yes  
☒ No

7. In addition, what was the inmate's race? Please select one or more of the following racial categories:

- ☒ White  
☐ Black or African American  
☐ American Indian or Alaska Native  
☐ Asian  
☐ Native Hawaiian or Pacific Islander  
☐ Some other race

→ Please Specify:

8. On what date was the inmate admitted to one of your correctional facilities?

1 2 0 5 2 0 1 1  
MONTH DAY YEAR

9. For what offense(s) was the inmate being held?

- a. S Escape Agg Escape  
b. Firearm Convicted Felon  
c. Simple Burglary of Inhab dwelling  
d.  
e.

10. Since admission, did the inmate ever stay overnight in a mental health facility?

- ☐ Yes  
☐ No  
☒ Don't Know

11. Where did the inmate die?

- ☐ In a general housing unit in the facility or in a general housing unit on prison grounds  
☐ In a segregation unit  
☒ In a special medical unit/infirmery within your facility  
☐ In a special mental health services unit within your facility  
☐ In a medical center outside your facility  
☐ In a mental health center outside your facility  
☐ While in transit  
☐ Elsewhere

→ Please Specify:



Are the results of a medical examiner's or coroner's evaluation (such as an autopsy, postmortem exam, or review of medical records) available to establish an official cause of death?

- ☐ YES → **CONTINUE TO Q13**  
☐ Evaluation complete—results are pending

→ **SKIP REMAINING QUESTIONS AND SUBMIT THIS FORM—YOU WILL BE CONTACTED AT A LATER TIME FOR THE CAUSE OF DEATH**

- ☒ No evaluation is planned → **CONTINUE TO Q13**

**13. What was the cause of death? \*\*\* Please SPECIFY cause of death—it is critical information\*\*\***

- ☒ Illness—Exclude AIDS-related deaths [Specify] → Amyotrophic Lateral sclerosis, Huypothyrod
- ☐ Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Accidental alcohol/drug intoxication [Describe] →
- ☐ Accidental injury to self [Describe] →
- ☐ Accidental injury by other (e.g., vehicular accidents during transport) [Describe] →
- ☐ Suicide (e.g., hanging, knife/cutting instrument, intentional drug overdose) [Describe] →
- ☐ Homicide [Describe] →
- ☐ Other cause(s) [Specify] →

**14. Where did the incident (e.g., accident, suicide, or homicide) causing the death take place?**

- ☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

- ☐ In the prison facility or on the prison grounds

[PLEASE SPECIFY]

- ☐ In the inmate's cell/room  
☐ In a temporary holding area/lockup  
☐ In a common area within the facility (e.g., yard, library, cafeteria)  
☐ In a special medical unit/infirmery  
☐ In a special mental health services unit  
☐ In a segregation unit  
☐ On death row, special unit awaiting capital punishment  
☐ Elsewhere within the prison facility

Please Specify:

- ☐ Outside the prison facility (e.g., while on work release or on work detail)  
☐ Elsewhere

Please Specify:

**15. When did the incident (e.g., accident, suicide, or homicide) causing the death occur?**

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16. Excluding emergency care provided at the time of death, did the inmate receive any of the following medical services for the medical condition that caused his/her death after admission to your correctional facilities?

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

	YES	NO	DON'T KNOW
a. Evaluated by physician/medical staff .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnostic tests (e.g., X-rays, MRI) .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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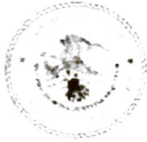
**PLEASE PROVIDE A  
RESPONSE FOR  
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17. Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? (If multiple conditions caused the death and any of the conditions were pre-existing, mark "Pre-existing medical condition.")

- ☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide
- ☐ Pre-existing medical condition
- ☐ Deceased developed condition after admission
- ☒ Could not be determined

Please add any additional notes regarding this death here:



Form NPS-4A  
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STATE PRISON INMATE  
DEATH REPORT**

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BUREAU OF JUSTICE STATISTICS  
AND ACTING AS COLLECTION AGENT:  
RTI INTERNATIONAL
**FORM COMPLETED BY:**

Name

Title

Official  
Address

Telephone

City

FAX

State

Zip

E-mail

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- Under your jurisdiction but on AWOL or escape-status at the time of death

**BURDEN STATEMENT**

Under the Paperwork Reduction Act, we cannot ask you to respond to a collection of information unless it displays a currently valid OMB control number. The burden of this collection is estimated to average 30 minutes per each reported death, including reviewing instructions, searching existing data sources, gathering necessary data, and completing and reviewing this form. Send comments regarding this burden estimate or any aspect of this survey, including suggestions for reducing this burden, to the Director, Bureau of Justice Statistics, 810 Seventh Street, NW, Washington, DC 20531. Do not send your completed form to this address.

# STATE PRISON INMATE DEATH REPORT

1. What was the inmate's name?

Berry Floyd

LAST FIRST MI

2. On what date did the inmate die?

0 5 1 7 2 0 1 9

MONTH DAY YEAR

3. What was the name and location of the correctional facility involved?

Facility Name:

ELAYN HUNT CORRECTIONAL CENTER

Facility City:

SAINT GABRIEL

Facility State:

LA

4. What was the inmate's date of birth?

0 6 1 2 1 9 4 7

MONTH DAY YEAR

5. What was the inmate's sex?

- ☒ Male  
☐ Female

6. Was the inmate of Hispanic, Latino, or Spanish origin?

- ☐ Yes  
☒ No

7. In addition, what was the inmate's race? Please select one or more of the following racial categories:

- ☐ White  
☒ Black or African American  
☐ American Indian or Alaska Native  
☐ Asian  
☐ Native Hawaiian or Pacific Islander  
☐ Some other race

→ Please Specify:

8. On what date was the inmate admitted to one of your correctional facilities?

1 2 2 3 2 0 0 3

MONTH DAY YEAR

9. For what offense(s) was the inmate being held?

a. Manslaughter

b.

c.

d.

e.

10. Since admission, did the inmate ever stay overnight in a mental health facility?

- ☐ Yes  
☐ No  
☒ Don't Know

11. Where did the inmate die?

- ☐ In a general housing unit in the facility or in a general housing unit on prison grounds  
☐ In a segregation unit  
☐ In a special medical unit/infirmery within your facility  
☐ In a special mental health services unit within your facility  
☒ In a medical center outside your facility  
☐ In a mental health center outside your facility  
☐ While in transit  
☐ Elsewhere

→ Please Specify:



2. Are the results of a medical examiner's or coroner's evaluation (such as an autopsy, postmortem exam, or review of medical records) available to establish an official cause of death?

☒ YES → **CONTINUE TO Q13**

☐ Evaluation complete—results are pending

→ **SKIP REMAINING QUESTIONS AND SUBMIT THIS FORM—YOU WILL BE CONTACTED AT A LATER TIME FOR THE CAUSE OF DEATH**

☐ No evaluation is planned → **CONTINUE TO Q13**

13. What was the cause of death? \*\*\* Please SPECIFY cause of death—it is critical information\*\*\*

☒ Illness—Exclude AIDS-related deaths [Specify] → Cancer

☐ Acquired Immune Deficiency Syndrome (AIDS)

☐ Accidental alcohol/drug intoxication [Describe] →

☐ Accidental injury to self [Describe] →

☐ Accidental injury by other (e.g., vehicular accidents during transport) [Describe] →

☐ Suicide (e.g., hanging, knife/cutting instrument, intentional drug overdose) [Describe] →

☐ Homicide [Describe] →

☐ Other cause(s) [Specify] →

14. Where did the incident (e.g., accident, suicide, or homicide) causing the death take place?

☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

☐ In the prison facility or on the prison grounds

[PLEASE SPECIFY]

☐ In the inmate's cell/room

☐ In a temporary holding area/lockup

☐ In a common area within the facility (e.g., yard, library, cafeteria)

☐ In a special medical unit/infirmery

☐ In a special mental health services unit

☐ In a segregation unit

☐ On death row, special unit awaiting capital punishment

☐ Elsewhere within the prison facility

→ Please Specify:

☐ Outside the prison facility (e.g., while on work release or on work detail)

☐ Elsewhere

→ Please Specify:

15. When did the incident (e.g., accident, suicide, or homicide) causing the death occur?

☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

☐ Morning (6 am to Noon)

☐ Afternoon (Noon to 6 pm)

☐ Evening (6 pm to Midnight)

☐ Overnight (Midnight to 6 am)

16. Excluding emergency care provided at the time of death, did the inmate receive any of the following medical services for the medical condition that caused his/her death after admission to your correctional facilities?

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

	YES	NO	DON'T KNOW
a. Evaluated by physician/medical staff .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnostic tests (e.g., X-rays, MRI) .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Treatment/care other than medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Surgery .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
f. Confinement in special medical unit .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PLEASE PROVIDE A  
RESPONSE FOR  
EACH ITEM (a-f)**

17. Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? (If multiple conditions caused the death and any of the conditions were pre-existing, mark "Pre-existing medical condition.")

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

☐ Pre-existing medical condition

☒ Deceased developed condition after admission

☐ Could not be determined

Please add any additional notes regarding this death here:



16. Excluding emergency care provided at the time of death, did the inmate receive any of the following medical services for the medical condition that caused his/her death after admission to your correctional facilities?

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

	YES	NO	DON'T KNOW
a. Evaluated by physician/medical staff .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnostic tests (e.g., X-rays, MRI) .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Treatment/care other than medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Surgery .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
f. Confinement in special medical unit .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PLEASE PROVIDE A  
RESPONSE FOR  
EACH ITEM (a-f)**

17. Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? (If multiple conditions caused the death and any of the conditions were pre-existing, mark "Pre-existing medical condition.")

- ☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide
- ☐ Pre-existing medical condition
- ☒ Deceased developed condition after admission
- ☐ Could not be determined

Please add any additional notes regarding this death here:

**Form NPS-4A  
(Addendum)**
**MORTALITY IN CORRECTIONAL INSTITUTIONS 2019  
STATE PRISON INMATE  
DEATH REPORT**

U.S. DEPARTMENT OF JUSTICE  
BUREAU OF JUSTICE STATISTICS  
AND ACTING AS COLLECTION AGENT:  
RTI INTERNATIONAL

**FORM COMPLETED BY:**

Name	<input type="text"/>	Title	<input type="text"/>
Official Address	<input type="text"/>	Telephone	<input type="text"/>
City	<input type="text"/>	FAX	<input type="text"/>
State	<input type="text"/>	Zip	<input type="text"/>
		E-mail	<input type="text"/>

**Instructions for Completion**If no deaths occurred in 2019:

- You do not need to complete this form.

If you had more than one death in 2019:

- Make copies of this form for each additional death.
- Complete the entire form for each inmate death.
- Once your death records are complete, there are several ways to submit a death report:

**ONLINE:** Complete the report online at: <https://bjsmci.rti.org>

**E-MAIL:** [bjsmci@rti.org](mailto:bjsmci@rti.org)

**FAX (TOLL-FREE):** (866) 800-9179

**MAIL:** RTI International, Attn: Data Capture  
Project #: 0215015.001.300.117.102.100  
5265 Capital Boulevard  
Raleigh, NC 27690-1652

*If you need assistance, contact the data collection team at RTI International toll-free at (800) 344-1387 or [bjsmci@rti.org](mailto:bjsmci@rti.org)*

**What deaths should be reported?****INCLUDE deaths of ALL persons...**

- Confined in your correctional facilities, whether housed under your jurisdiction or that of another state
- Under your jurisdiction but housed in private correctional facilities, whether located in or out of state
- Under your jurisdiction but in special facilities (e.g., medical/treatment/release centers, halfway houses, police/court lockups, or work farms)
- In transit to or from your facilities while under your supervision

**EXCLUDE deaths of ALL persons...**

- Executed in your state
- Confined in local jail facilities, whether located in or out of state
- Under your jurisdiction but housed in a state-operated correctional facility in another state or in a federal facility
- Under probation or parole supervision in your state
- Under your jurisdiction but on AWOL or escape-status at the time of death

**BURDEN STATEMENT**

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# STATE PRISON INMATE DEATH REPORT

Are the  
review

1. What was the inmate's name?

Brown Darrien  
LAST FIRST MI

2. On what date did the inmate die?

0 2 1 9 2 0 1 9  
MONTH DAY YEAR

3. What was the name and location of the correctional facility involved?

Facility Name:

ELAYN HUNT CORRECTIONAL CENTER

Facility City:

SAINT GABRIEL

Facility State:

LA

4. What was the inmate's date of birth?

0 7 2 2 1 9 6 7  
MONTH DAY YEAR

5. What was the inmate's sex?

- ☒ Male  
☐ Female

6. Was the inmate of Hispanic, Latino, or Spanish origin?

- ☐ Yes  
☒ No

7. In addition, what was the inmate's race? Please select one or more of the following racial categories:

- ☐ White  
☒ Black or African American  
☐ American Indian or Alaska Native  
☐ Asian  
☐ Native Hawaiian or Pacific Islander  
☐ Some other race

Please Specify:

8. On what date was the inmate admitted to one of your correctional facilities?

0 2 2 1 1 9 9 5  
MONTH DAY YEAR

9. For what offense(s) was the inmate being held?

a. Robbery

b. Agg Rape

c.

d.

e.

10. Since admission, did the inmate ever stay overnight in a mental health facility?

- ☐ Yes  
☐ No  
☒ Don't Know

11. Where did the inmate die?

- ☐ In a general housing unit in the facility or in a general housing unit on prison grounds  
☐ In a segregation unit  
☐ In a special medical unit/infirmarv within your facility  
☐ In a special mental health services unit within your facility  
☒ In a medical center outside your facility  
☐ In a mental health center outside your facility  
☐ While in transit  
☐ Elsewhere

Please Specify:

2. Are the results of a medical examiner's or coroner's evaluation (such as an autopsy, postmortem exam, or review of medical records) available to establish an official cause of death?

☐ YES → **CONTINUE TO Q13**

☐ Evaluation complete—results are pending

→ **SKIP REMAINING QUESTIONS AND SUBMIT THIS FORM—YOU WILL BE CONTACTED AT A LATER TIME FOR THE CAUSE OF DEATH**

☒ No evaluation is planned → **CONTINUE TO Q13**

13. What was the cause of death? \*\*\* Please SPECIFY cause of death—it is critical information\*\*\*

☒ Illness—Exclude AIDS-related deaths [Specify] → anoxic brain injury secondary to influenza A

☐ Acquired Immune Deficiency Syndrome (AIDS)

☐ Accidental alcohol/drug intoxication [Describe] →

☐ Accidental injury to self [Describe] →

☐ Accidental injury by other (e.g., vehicular accidents during transport) [Describe] →

☐ Suicide (e.g., hanging, knife/cutting instrument, intentional drug overdose) [Describe] →

☐ Homicide [Describe] →

☐ Other cause(s) [Specify] →

14. Where did the incident (e.g., accident, suicide, or homicide) causing the death take place?

☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

☐ In the prison facility or on the prison grounds

[PLEASE SPECIFY]

☐ In the inmate's cell/room

☐ In a temporary holding area/lockup

☐ In a common area within the facility (e.g., yard, library, cafeteria)

☐ In a special medical unit/infirmery

☐ In a special mental health services unit

☐ In a segregation unit

☐ On death row, special unit awaiting capital punishment

☐ Elsewhere within the prison facility

→ Please Specify:

☐ Outside the prison facility (e.g., while on work release or on work detail)

☐ Elsewhere

→ Please Specify:

15. When did the incident (e.g., accident, suicide, or homicide) causing the death occur?

☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

☐ Morning (6 am to Noon)

☐ Afternoon (Noon to 6 pm)

☐ Evening (6 pm to Midnight)

☐ Overnight (Midnight to 6 am)



16. Excluding emergency care provided at the time of death, did the inmate receive any of the following medical services for the medical condition that caused his/her death after admission to your correctional facilities?

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

	YES	NO	DON'T KNOW
a. Evaluated by physician/medical staff .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnostic tests (e.g., X-rays, MRI) .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Treatment/care other than medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Surgery .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
f. Confinement in special medical unit .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

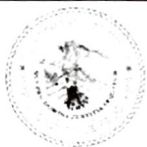
**PLEASE PROVIDE A  
RESPONSE FOR  
EACH ITEM (a-f)**

17. Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? (If multiple conditions caused the death and any of the conditions were pre-existing, mark "Pre-existing medical condition.")

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

- ☒ Pre-existing medical condition
- ☐ Deceased developed condition after admission
- ☐ Could not be determined

Please add any additional notes regarding this death here:

Form NPS-4A  
(Addendum)
**MORTALITY IN CORRECTIONAL INSTITUTIONS 2019**  
**STATE PRISON INMATE**  
**DEATH REPORT**

 U.S. DEPARTMENT OF JUSTICE  
 BUREAU OF JUSTICE STATISTICS  
 AND ACTING AS COLLECTION AGENT:  
 RTI INTERNATIONAL
**FORM COMPLETED BY:**

Name

Title

Official  
Address

Telephone

City

FAX

State

Zip

E-mail

**Instructions for Completion**If no deaths occurred in 2019:

- You do not need to complete this form.

If you had more than one death in 2019:

- Make copies of this form for each additional death.
- Complete the entire form for each inmate death.
- Once your death records are complete, there are several ways to submit a death report:

 ONLINE: Complete the report online at: <https://bjsmci.rti.org>

 MAIL: RTI International, Attn: Data Capture  
 Project #: 0215015.001.300.117.102.100  
 5265 Capital Boulevard  
 Raleigh, NC 27690-1652

 E-MAIL: [bjsmci@rti.org](mailto:bjsmci@rti.org)

FAX (TOLL-FREE): (866) 800-9179

 If you need assistance, contact the data collection team at RTI International toll-free at (800) 344-1387 or [bjsmci@rti.org](mailto:bjsmci@rti.org)
**What deaths should be reported?****INCLUDE** deaths of ALL persons...

- Confined in your correctional facilities, whether housed under your jurisdiction or that of another state
- Under your jurisdiction but housed in private correctional facilities, whether located in or out of state
- Under your jurisdiction but in special facilities (e.g., medical/treatment/release centers, halfway houses, police/court lockups, or work farms)
- In transit to or from your facilities while under your supervision

**EXCLUDE** deaths of ALL persons...

- Executed in your state
- Confined in local jail facilities, whether located in or out of state
- Under your jurisdiction but housed in a state-operated correctional facility in another state or in a federal facility
- Under probation or parole supervision in your state
- Under your jurisdiction but on AWOL or escape-status at the time of death

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Are the review

# STATE PRISON INMATE DEATH REPORT

1. What was the inmate's name?

Brown Preston J  
LAST FIRST MI

2. On what date did the inmate die?

1 1 2 0 2 0 1 9  
MONTH DAY YEAR

3. What was the name and location of the correctional facility involved?

Facility Name:  
ELAYN HUNT CORRECTIONAL CENTER

Facility City: SAINT GABRIEL Facility State: LA

4. What was the inmate's date of birth?

0 3 2 5 1 9 3 8  
MONTH DAY YEAR

5. What was the inmate's sex?

- ☒ Male  
☐ Female

6. Was the inmate of Hispanic, Latino, or Spanish origin?

- ☐ Yes  
☒ No

7. In addition, what was the inmate's race? Please select one or more of the following racial categories:

- ☒ White  
☐ Black or African American  
☐ American Indian or Alaska Native  
☐ Asian  
☐ Native Hawaiian or Pacific Islander  
☐ Some other race

Please Specify:

8. On what date was the inmate admitted to one of your correctional facilities?

0 6 0 1 2 0 1 9  
MONTH DAY YEAR

9. For what offense(s) was the inmate being held?

- a. ATT Failure to register as a sex offender  
b.  
c.  
d.  
e.

10. Since admission, did the inmate ever stay overnight in a mental health facility?

- ☐ Yes  
☐ No  
☒ Don't Know

11. Where did the inmate die?

- ☐ In a general housing unit in the facility or in a general housing unit on prison grounds  
☐ In a segregation unit  
☐ In a special medical unit/infirmarary within your facility  
☐ In a special mental health services unit within your facility  
☒ In a medical center outside your facility  
☐ In a mental health center outside your facility  
☐ While in transit  
☐ Elsewhere

Please Specify:

Are the results of a medical examiner's or coroner's evaluation (such as an autopsy, postmortem exam, or review of medical records) available to establish an official cause of death?

- ☒ YES → **CONTINUE TO Q13**  
☐ Evaluation complete—results are pending

→ **SKIP REMAINING QUESTIONS AND SUBMIT THIS FORM—YOU WILL BE CONTACTED AT A LATER TIME FOR THE CAUSE OF DEATH**

- ☐ No evaluation is planned → **CONTINUE TO Q13**

**13. What was the cause of death? \*\*\* Please SPECIFY cause of death—it is critical information\*\*\***

- ☒ Illness—Exclude AIDS-related deaths [Specify] → Pallative Care/Sepsis
- ☐ Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Accidental alcohol/drug intoxication [Describe] →
- ☐ Accidental injury to self [Describe] →
- ☐ Accidental injury by other (e.g., vehicular accidents during transport) [Describe] →
- ☐ Suicide (e.g., hanging, knife/cutting instrument, intentional drug overdose) [Describe] →
- ☐ Homicide [Describe] →
- ☐ Other cause(s) [Specify] →

**14. Where did the incident (e.g., accident, suicide, or homicide) causing the death take place?**

- ☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

- ☐ In the prison facility or on the prison grounds

(PLEASE SPECIFY)

- ☐ In the inmate's cell/room  
☐ In a temporary holding area/lockup  
☐ In a common area within the facility (e.g., yard, library, cafeteria)  
☐ In a special medical unit/infirmery  
☐ In a special mental health services unit  
☐ In a segregation unit  
☐ On death row, special unit awaiting capital punishment  
☐ Elsewhere within the prison facility

Please Specify:

- ☐ Outside the prison facility (e.g., while on work release or on work detail)

- ☐ Elsewhere

Please Specify:

**15. When did the incident (e.g., accident, suicide, or homicide) causing the death occur?**

- ☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

- ☐ Morning (6 am to Noon)  
☐ Afternoon (Noon to 6 pm)  
☐ Evening (6 pm to Midnight)  
☐ Overnight (Midnight to 6 am)



16. Excluding emergency care provided at the time of death, did the inmate receive any of the following medical services for the medical condition that caused his/her death after admission to your correctional facilities?

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

	YES	NO	DON'T KNOW
a. Evaluated by physician/medical staff .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnostic tests (e.g., X-rays, MRI) .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Treatment/care other than medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Surgery .....	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
f. Confinement in special medical unit .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

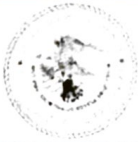
**PLEASE PROVIDE A  
RESPONSE FOR  
EACH ITEM (a-f)**

17. Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? (If multiple conditions caused the death and any of the conditions were pre-existing, mark "Pre-existing medical condition.")

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

- ☒ Pre-existing medical condition  
☐ Deceased developed condition after admission  
☐ Could not be determined

Please add any additional notes regarding this death here:

Form NPS-4A  
(Addendum)
**MORTALITY IN CORRECTIONAL INSTITUTIONS 2019  
STATE PRISON INMATE  
DEATH REPORT**

 U.S. DEPARTMENT OF JUSTICE  
BUREAU OF JUSTICE STATISTICS  
AND ACTING AS COLLECTION AGENT:  
RTI INTERNATIONAL
**FORM COMPLETED BY:**

Name

Title

Official  
Address

Telephone

City

FAX

State

Zip

E-mail

**Instructions for Completion**

If no deaths occurred in 2019:

- You do not need to complete this form.

If you had more than one death in 2019:

- Make copies of this form for each additional death.
- Complete the entire form for each inmate death.
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ONLINE: Complete the report online at: <https://bjsmci.rti.org>

MAIL: RTI International, Attn: Data Capture  
Project #: 0215015.001.300.117.102.100  
5265 Capital Boulevard  
Raleigh, NC 27690-1652

E-MAIL: [bjsmci@rti.org](mailto:bjsmci@rti.org)

FAX (TOLL-FREE): (866) 800-9179

If you need assistance, contact the data collection team at RTI International toll-free at (800) 344-1387 or [bjsmci@rti.org](mailto:bjsmci@rti.org)

**What deaths should be reported?****INCLUDE** deaths of ALL persons...

- Confined in your correctional facilities, whether housed under your jurisdiction or that of another state
- Under your jurisdiction but housed in private correctional facilities, whether located in or out of state
- Under your jurisdiction but in special facilities (e.g., medical/treatment/release centers, halfway houses, police/court lockups, or work farms)
- In transit to or from your facilities while under your supervision

**EXCLUDE** deaths of ALL persons...

- Executed in your state
- Confined in local jail facilities, whether located in or out of state
- Under your jurisdiction but housed in a state-operated correctional facility in another state or in a federal facility
- Under probation or parole supervision in your state
- Under your jurisdiction but on AWOL or escape-status at the time of death

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# STATE PRISON INMATE DEATH REPORT

Are the review

1. What was the inmate's name?

Coleman Andre

LAST FIRST MI

2. On what date did the inmate die?

0 3 1 3 2 0 1 9

MONTH DAY YEAR

3. What was the name and location of the correctional facility involved?

Facility Name:

ELAYN HUNT CORRECTIONAL CENTER

Facility City:

SAINT GABRIEL

Facility State:

LA

4. What was the inmate's date of birth?

0 2 1 9 1 9 7 7

MONTH DAY YEAR

5. What was the inmate's sex?

- ☒ Male  
☐ Female

6. Was the inmate of Hispanic, Latino, or Spanish origin?

- ☐ Yes  
☒ No

7. In addition, what was the inmate's race? Please select one or more of the following racial categories:

- ☐ White  
☒ Black or African American  
☐ American Indian or Alaska Native  
☐ Asian  
☐ Native Hawaiian or Pacific Islander  
☐ Some other race

→ Please Specify:

8. On what date was the inmate admitted to one of your correctional facilities?

0 8 2 9 2 0 1 8

MONTH DAY YEAR

9. For what offense(s) was the inmate being held?

- a. Theft of a motor vehicle  
b.   
c.   
d.   
e.

10. Since admission, did the inmate ever stay overnight in a mental health facility?

- ☐ Yes  
☐ No  
☒ Don't Know

11. Where did the inmate die?

- ☐ In a general housing unit in the facility or in a general housing unit on prison grounds  
☐ In a segregation unit  
☐ In a special medical unit/infirmary within your facility  
☐ In a special mental health services unit within your facility  
☒ In a medical center outside your facility  
☐ In a mental health center outside your facility  
☐ While in transit  
☐ Elsewhere

→ Please Specify:

to one of

Are the results of a medical examiner's or coroner's evaluation (such as an autopsy, postmortem exam, or review of medical records) available to establish an official cause of death?

- ☐ YES → **CONTINUE TO Q13**
- ☐ Evaluation complete—results are pending

→ **SKIP REMAINING QUESTIONS AND SUBMIT THIS FORM—YOU WILL BE CONTACTED AT A LATER TIME FOR THE CAUSE OF DEATH**

- ☒ No evaluation is planned → **CONTINUE TO Q13**

13. What was the cause of death? \*\*\* Please SPECIFY cause of death—it is critical information\*\*\*

- ☒ Illness—Exclude AIDS-related deaths [Specify] → Heart Attack
- ☐ Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Accidental alcohol/drug intoxication [Describe] →
- ☐ Accidental injury to self [Describe] →
- ☐ Accidental injury by other (e.g., vehicular accidents during transport) [Describe] →
- ☐ Suicide (e.g., hanging, knife/cutting instrument, intentional drug overdose) [Describe] →
- ☐ Homicide [Describe] →
- ☐ Other cause(s) [Specify] →

14. Where did the incident (e.g., accident, suicide, or homicide) causing the death take place?

- ☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

- ☐ In the prison facility or on the prison grounds

[PLEASE SPECIFY]

- ☐ In the inmate's cell/room
- ☐ In a temporary holding area/lockup
- ☐ In a common area within the facility (e.g., yard, library, cafeteria)
- ☐ In a special medical unit/infirmery
- ☐ In a special mental health services unit
- ☐ In a segregation unit
- ☐ On death row, special unit awaiting capital punishment
- ☐ Elsewhere within the prison facility

Please Specify:

- ☐ Outside the prison facility (e.g., while on work release or on work detail)
- ☐ Elsewhere

Please Specify:

15. When did the incident (e.g., accident, suicide, or homicide) causing the death occur?

- ☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related
- ☐ Morning (6 am to Noon)
- ☐ Afternoon (Noon to 6 pm)
- ☐ Evening (6 pm to Midnight)
- ☐ Overnight (Midnight to 6 am)



16. Excluding emergency care provided at the time of death, did the inmate receive any of the following medical services for the medical condition that caused his/her death after admission to your correctional facilities?

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

	YES	NO	DON'T KNOW
a. Evaluated by physician/medical staff .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnostic tests (e.g., X-rays, MRI) .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Treatment/care other than medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Surgery .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
f. Confinement in special medical unit .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PLEASE PROVIDE A  
RESPONSE FOR  
EACH ITEM (a-f)**

17. Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? (If multiple conditions caused the death and any of the conditions were pre-existing, mark "Pre-existing medical condition.")

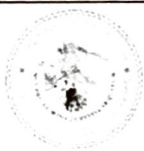
☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

☒ Pre-existing medical condition

☐ Deceased developed condition after admission

☐ Could not be determined

Please add any additional notes regarding this death here:

Form NPS-4A  
(Addendum)
**MORTALITY IN CORRECTIONAL INSTITUTIONS 2019**  
**STATE PRISON INMATE**  
**DEATH REPORT**

 U.S. DEPARTMENT OF JUSTICE  
 BUREAU OF JUSTICE STATISTICS  
 AND ACTING AS COLLECTION AGENT:

RTI INTERNATIONAL

**FORM COMPLETED BY:**

Name

Title

Official  
Address

Telephone

City

FAX

State

Zip

E-mail

**Instructions for Completion**If no deaths occurred in 2019:

- You do not need to complete this form.

If you had more than one death in 2019:

- Make copies of this form for each additional death.
- Complete the entire form for each inmate death.
- Once your death records are complete, there are several ways to submit a death report:

**ONLINE:** Complete the report online at: <https://bjsmci.rti.org>
**MAIL:** RTI International, Attn: Data Capture  
 Project #: 0215015.001.300.117.102.100  
 5265 Capital Boulevard  
 Raleigh, NC 27690-1652

**E-MAIL:** [bjsmci@rti.org](mailto:bjsmci@rti.org)
**FAX (TOLL-FREE):** (866) 800-9179

*If you need assistance, contact the data collection team at RTI International toll-free at (800) 344-1387 or [bjsmci@rti.org](mailto:bjsmci@rti.org)*
**What deaths should be reported?****INCLUDE** deaths of ALL persons...

- Confined in your correctional facilities, whether housed under your jurisdiction or that of another state
- Under your jurisdiction but housed in private correctional facilities, whether located in or out of state
- Under your jurisdiction but in special facilities (e.g., medical/treatment/release centers, halfway houses, police/court lockups, or work farms)
- In transit to or from your facilities while under your supervision

**EXCLUDE** deaths of ALL persons...

- Executed in your state
- Confined in local jail facilities, whether located in or out of state
- Under your jurisdiction but housed in a state-operated correctional facility in another state or in a federal facility
- Under probation or parole supervision in your state
- Under your jurisdiction but on AWOL or escape-status at the time of death

**BURDEN STATEMENT**

Under the Paperwork Reduction Act, we cannot ask you to respond to a collection of information unless it displays a currently valid OMB control number. The burden of this collection is estimated to average 30 minutes per each reported death, including reviewing instructions, searching existing data sources, gathering necessary data, and completing and reviewing this form. Send comments regarding this burden estimate or any aspect of this survey, including suggestions for reducing this burden, to the Director, Bureau of Justice Statistics, 810 Seventh Street, NW, Washington, DC 20531. Do not send your completed form to this address.



# STATE PRISON INMATE DEATH REPORT

1. What was the inmate's name?

Craddock Timothy

LAST FIRST MI

2. On what date did the inmate die?

0 3 0 4 2 0 1 9

MONTH DAY YEAR

3. What was the name and location of the correctional facility involved?

Facility Name:  
ELAYN HUNT CORRECTIONAL CENTER

Facility City: SAINT GABRIEL Facility State: LA

4. What was the inmate's date of birth?

0 9 0 3 1 9 6 4

MONTH DAY YEAR

5. What was the inmate's sex?

- ☒ Male  
☐ Female

6. Was the inmate of Hispanic, Latino, or Spanish origin?

- ☐ Yes  
☒ No

7. In addition, what was the inmate's race? Please select one or more of the following racial categories:

- ☒ White  
☐ Black or African American  
☐ American Indian or Alaska Native  
☐ Asian  
☐ Native Hawaiian or Pacific Islander  
☐ Some other race

→ Please Specify:

8. On what date was the inmate admitted to one of your correctional facilities?

1 2 0 5 2 0 1 6

MONTH DAY YEAR

9. For what offense(s) was the inmate being held?

- a. Distribution of Oxycodone  
b.   
c.   
d.   
e.

10. Since admission, did the inmate ever stay overnight in a mental health facility?

- ☐ Yes  
☐ No  
☒ Don't Know

11. Where did the inmate die?

- ☐ In a general housing unit in the facility or in a general housing unit on prison grounds  
☐ In a segregation unit  
☐ In a special medical unit/infirmary within your facility  
☐ In a special mental health services unit within your facility  
☒ In a medical center outside your facility  
☐ In a mental health center outside your facility  
☐ While in transit  
☐ Elsewhere

→ Please Specify:

Admitted to one

results of a medical examiner's or coroner's evaluation (such as an autopsy, postmortem exam, or review of medical records) available to establish an official cause of death?

☐ YES → **CONTINUE TO Q13**

☐ Evaluation complete—results are pending

→ **SKIP REMAINING QUESTIONS AND SUBMIT THIS FORM—YOU WILL BE CONTACTED AT A LATER TIME FOR THE CAUSE OF DEATH**

☒ No evaluation is planned → **CONTINUE TO Q13**

**13. What was the cause of death? \*\*\* Please SPECIFY cause of death—it is critical information\*\*\***

☒ Illness—Exclude AIDS-related deaths [Specify] → Liver Disease

☐ Acquired Immune Deficiency Syndrome (AIDS)

☐ Accidental alcohol/drug intoxication [Describe] →

☐ Accidental injury to self [Describe] →

☐ Accidental injury by other (e.g., vehicular accidents during transport) [Describe] →

☐ Suicide (e.g., hanging, knife/cutting instrument, intentional drug overdose) [Describe] →

☐ Homicide [Describe] →

☐ Other cause(s) [Specify] →

**14. Where did the incident (e.g., accident, suicide, or homicide) causing the death take place?**

☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

☐ In the prison facility or on the prison grounds

[PLEASE SPECIFY]

- ☐ In the inmate's cell/room
- ☐ In a temporary holding area/lockup
- ☐ In a common area within the facility (e.g., yard, library, cafeteria)
- ☐ In a special medical unit/infirmery
- ☐ In a special mental health services unit
- ☐ In a segregation unit
- ☐ On death row, special unit awaiting capital punishment
- ☐ Elsewhere within the prison facility

→ Please Specify:

☐ Outside the prison facility (e.g., while on work release or on work detail)

☐ Elsewhere

→ Please Specify:

**15. When did the incident (e.g., accident, suicide, or homicide) causing the death occur?**

☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

☐ Morning (6 am to Noon)

☐ Afternoon (Noon to 6 pm)

☐ Evening (6 pm to Midnight)

☐ Overnight (Midnight to 6 am)



16. Excluding emergency care provided at the time of death, did the inmate receive any of the following medical services for the medical condition that caused his/her death after admission to your correctional facilities?

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

	YES	NO	DON'T KNOW
a. Evaluated by physician/medical staff .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnostic tests (e.g., X-rays, MRI) .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Treatment/care other than medications .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
e. Surgery .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Confinement in special medical unit .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PLEASE PROVIDE A  
RESPONSE FOR  
EACH ITEM (a–f)**

17. Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? (If multiple conditions caused the death and any of the conditions were pre-existing, mark "Pre-existing medical condition.")

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

- ☒ Pre-existing medical condition
- ☐ Deceased developed condition after admission
- ☐ Could not be determined

Please add any additional notes regarding this death here:

Form NPS-4A  
(Addendum)
**MORTALITY IN CORRECTIONAL INSTITUTIONS 2019**  
**STATE PRISON INMATE**  
**DEATH REPORT**

 U.S. DEPARTMENT OF JUSTICE  
 BUREAU OF JUSTICE STATISTICS  
 AND ACTING AS COLLECTION AGENT:  
 RTI INTERNATIONAL
**FORM COMPLETED BY:**

Name

Title

Official  
Address

Telephone

City

FAX

State

Zip

E-mail

**Instructions for Completion**If no deaths occurred in 2019:

- You do not need to complete this form.

If you had more than one death in 2019:

- Make copies of this form for each additional death.
- Complete the entire form for each inmate death.
- Once your death records are complete, there are several ways to submit a death report:

 ONLINE: Complete the report online at: <https://bjsmci.rti.org>

 MAIL: RTI International, Attn: Data Capture  
 Project #: 0215015.001.300.117.102.100  
 5265 Capital Boulevard  
 Raleigh, NC 27690-1652

 E-MAIL: [bjsmci@rti.org](mailto:bjsmci@rti.org)

FAX (TOLL-FREE): (866) 800-9179

 If you need assistance, contact the data collection team at RTI International toll-free at (800) 344-1387 or [bjsmci@rti.org](mailto:bjsmci@rti.org)
**What deaths should be reported?****INCLUDE** deaths of ALL persons...

- Confined in your correctional facilities, whether housed under your jurisdiction or that of another state
- Under your jurisdiction but housed in private correctional facilities, whether located in or out of state
- Under your jurisdiction but in special facilities (e.g., medical/treatment/release centers, halfway houses, police/court lockups, or work farms)
- In transit to or from your facilities while under your supervision

**EXCLUDE** deaths of ALL persons...

- Executed in your state
- Confined in local jail facilities, whether located in or out of state
- Under your jurisdiction but housed in a state-operated correctional facility in another state or in a federal facility
- Under probation or parole supervision in your state
- Under your jurisdiction but on AWOL or escape-status at the time of death

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# STATE PRISON INMATE DEATH REPORT

Are the res review of n  
YE  
3

1. What was the inmate's name?

Farmer

LAST

John

FIRST

C

MI

2. On what date did the inmate die?

0 4

MONTH

2 5

DAY

2 0 1 9

YEAR

3. What was the name and location of the correctional facility involved?

Facility Name:

ELAYN HUNT CORRECTIONAL CENTER

Facility City:

SAINT GABRIEL

Facility State:

LA

4. What was the inmate's date of birth?

1 0

MONTH

2 4

DAY

1 9 6 2

YEAR

5. What was the inmate's sex?

☒ Male

☐ Female

6. Was the inmate of Hispanic, Latino, or Spanish origin?

☐ Yes

☒ No

7. In addition, what was the inmate's race? Please select one or more of the following racial categories:

☒ White

☐ Black or African American

☐ American Indian or Alaska Native

☐ Asian

☐ Native Hawaiian or Pacific Islander

☐ Some other race

→ Please Specify:

8. On what date was the inmate admitted to one of your correctional facilities?

1 1

MONTH

0 1

DAY

2 0 0 4

YEAR

9. For what offense(s) was the inmate being held?

a. Aggravated Incest

b. Agg Crime of Nature

c.

d.

e.

10. Since admission, did the inmate ever stay overnight in a mental health facility?

☐ Yes

☐ No

☒ Don't Know

11. Where did the inmate die?

☐ In a general housing unit in the facility or in a general housing unit on prison grounds

☐ In a segregation unit

☒ In a special medical unit/infirmarv within your facility

☐ In a special mental health services unit within your facility

☐ In a medical center outside your facility

☐ In a mental health center outside your facility

☐ While in transit

☐ Elsewhere

→ Please Specify:

Are the results of a medical examiner's or coroner's evaluation (such as an autopsy, postmortem exam, or review of medical records) available to establish an official cause of death?

- ☒ YES → **CONTINUE TO Q13**  
☐ Evaluation complete—results are pending

→ **SKIP REMAINING QUESTIONS AND SUBMIT THIS FORM—YOU WILL BE CONTACTED AT A LATER TIME FOR THE CAUSE OF DEATH**

- ☐ No evaluation is planned → **CONTINUE TO Q13**

**13. What was the cause of death? \*\*\* Please SPECIFY cause of death—it is critical information\*\*\***

- ☒ Illness—Exclude AIDS-related deaths [Specify] → Cardiac Arrest
- ☐ Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Accidental alcohol/drug intoxication [Describe] →
- ☐ Accidental injury to self [Describe] →
- ☐ Accidental injury by other (e.g., vehicular accidents during transport) [Describe] →
- ☐ Suicide (e.g., hanging, knife/cutting instrument, intentional drug overdose) [Describe] →
- ☐ Homicide [Describe] →
- ☐ Other cause(s) [Specify] →

**14. Where did the incident (e.g., accident, suicide, or homicide) causing the death take place?**

- ☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

- ☐ In the prison facility or on the prison grounds

[PLEASE SPECIFY]

- ☐ In the inmate's cell/room  
☐ In a temporary holding area/lockup  
☐ In a common area within the facility (e.g., yard, library, cafeteria)  
☐ In a special medical unit/infirmary  
☐ In a special mental health services unit  
☐ In a segregation unit  
☐ On death row, special unit awaiting capital punishment  
☐ Elsewhere within the prison facility

Please Specify:

- ☐ Outside the prison facility (e.g., while on work release or on work detail)

- ☐ Elsewhere

Please Specify:

**15. When did the incident (e.g., accident, suicide, or homicide) causing the death occur?**

- ☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

- ☐ Morning (6 am to Noon)  
☐ Afternoon (Noon to 6 pm)  
☐ Evening (6 pm to Midnight)  
☐ Overnight (Midnight to 6 am)



16. Excluding emergency care provided at the time of death, did the inmate receive any of the following medical services for the medical condition that caused his/her death after admission to your correctional facilities?

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

	YES	NO	DON'T KNOW
a. Evaluated by physician/medical staff .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnostic tests (e.g., X-rays, MRI) .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Treatment/care other than medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Surgery .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Confinement in special medical unit .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**PLEASE PROVIDE A  
RESPONSE FOR  
EACH ITEM (a-f)**

17. Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? (If multiple conditions caused the death and any of the conditions were pre-existing, mark "Pre-existing medical condition.")

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

☒ Pre-existing medical condition

☐ Deceased developed condition after admission

☐ Could not be determined

Please add any additional notes regarding this death here:

Form NPS-4A  
(Addendum)
**MORTALITY IN CORRECTIONAL INSTITUTIONS 2019  
STATE PRISON INMATE  
DEATH REPORT**

 U.S. DEPARTMENT OF JUSTICE  
BUREAU OF JUSTICE STATISTICS  
AND ACTING AS COLLECTION AGENT:  
RTI INTERNATIONAL
**FORM COMPLETED BY:**

Name	<input type="text"/>	Title	<input type="text"/>
Official Address	<input type="text"/>	Telephone	<input type="text"/>
City	<input type="text"/>	FAX	<input type="text"/>
State	<input type="text"/>	Zip	<input type="text"/>
		E-mail	<input type="text"/>

**Instructions for Completion**If no deaths occurred in 2019:

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If you had more than one death in 2019:

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- Complete the entire form for each inmate death.
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FAX (TOLL-FREE): (866) 800-9179

 MAIL: RTI International, Attn: Data Capture  
Project #: 0215015.001.300.117.102.100  
5265 Capital Boulevard  
Raleigh, NC 27690-1652

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- Confined in your correctional facilities, whether housed under your jurisdiction or that of another state
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- Under your jurisdiction but in special facilities (e.g., medical/treatment/release centers, halfway houses, police/court lockups, or work farms)
- In transit to or from your facilities while under your supervision

**EXCLUDE** deaths of ALL persons...

- Executed in your state
- Confined in local jail facilities, whether located in or out of state
- Under your jurisdiction but housed in a state-operated correctional facility in another state or in a federal facility
- Under probation or parole supervision in your state
- Under your jurisdiction but on AWOL or escape-status at the time of death

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# STATE PRISON INMATE DEATH REPORT

12.

1. What was the inmate's name?

Flanagan Joseph

LAST FIRST MI

2. On what date did the inmate die?

0 2 0 1 2 0 1 9

MONTH DAY YEAR

3. What was the name and location of the correctional facility involved?

Facility Name:

ELAYN HUNT CORRECTIONAL CENTER

Facility City:

SAINT GABRIEL

Facility State:

LA

4. What was the inmate's date of birth?

0 7 1 9 1 9 5 4

MONTH DAY YEAR

5. What was the inmate's sex?

- ☒ Male  
☐ Female

6. Was the inmate of Hispanic, Latino, or Spanish origin?

- ☐ Yes  
☒ No

7. In addition, what was the inmate's race? Please select one or more of the following racial categories:

- ☐ White  
☒ Black or African American  
☐ American Indian or Alaska Native  
☐ Asian  
☐ Native Hawaiian or Pacific Islander  
☐ Some other race

→ Please Specify:

8. On what date was the inmate admitted to one of your correctional facilities?

1 1 2 9 2 0 1 7

MONTH DAY YEAR

9. For what offense(s) was the inmate being held?

a. Aggravated Battery

b.

c.

d.

e.

10. Since admission, did the inmate ever stay overnight in a mental health facility?

- ☐ Yes  
☐ No  
☒ Don't Know

11. Where did the inmate die?

- ☐ In a general housing unit in the facility or in a general housing unit on prison grounds  
☐ In a segregation unit  
☒ In a special medical unit/infirmery within your facility  
☐ In a special mental health services unit within your facility  
☐ In a medical center outside your facility  
☐ In a mental health center outside your facility  
☐ While in transit  
☐ Elsewhere

→ Please Specify:

12. Are the results of a medical examiner's or coroner's evaluation (such as an autopsy, postmortem exam, or review of medical records) available to establish an official cause of death?

☐ YES → **CONTINUE TO Q13**

☐ Evaluation complete—results are pending

→ **SKIP REMAINING QUESTIONS AND SUBMIT THIS FORM—YOU WILL BE CONTACTED AT A LATER TIME FOR THE CAUSE OF DEATH**

☒ No evaluation is planned → **CONTINUE TO Q13**

13. What was the cause of death? \*\*\* Please SPECIFY cause of death—it is critical information\*\*\*

☒ Illness—Exclude AIDS-related deaths [Specify] → Liver Disease

☐ Acquired Immune Deficiency Syndrome (AIDS)

☐ Accidental alcohol/drug intoxication [Describe] →

☐ Accidental injury to self [Describe] →

☐ Accidental injury by other (e.g., vehicular accidents during transport) [Describe] →

☐ Suicide (e.g., hanging, knife/cutting instrument, intentional drug overdose) [Describe] →

☐ Homicide [Describe] →

☐ Other cause(s) [Specify] →

14. Where did the incident (e.g., accident, suicide, or homicide) causing the death take place?

☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

☐ In the prison facility or on the prison grounds

[PLEASE SPECIFY]

☐ In the inmate's cell/room

☐ In a temporary holding area/lockup

☐ In a common area within the facility (e.g., yard, library, cafeteria)

☐ In a special medical unit/infirmatary

☐ In a special mental health services unit

☐ In a segregation unit

☐ On death row, special unit awaiting capital punishment

☐ Elsewhere within the prison facility

→ Please Specify:

☐ Outside the prison facility (e.g., while on work release or on work detail)

☐ Elsewhere

→ Please Specify:

15. When did the incident (e.g., accident, suicide, or homicide) causing the death occur?

☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

☐ Morning (6 am to Noon)

☐ Afternoon (Noon to 6 pm)

☐ Evening (6 pm to Midnight)

☐ Overnight (Midnight to 6 am)



16. Excluding emergency care provided at the time of death, did the inmate receive any of the following medical services for the medical condition that caused his/her death after admission to your correctional facilities?

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

	YES	NO	DON'T KNOW
a. Evaluated by physician/medical staff .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnostic tests (e.g., X-rays, MRI) .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Treatment/care other than medications .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
e. Surgery .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
f. Confinement in special medical unit .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PLEASE PROVIDE A  
RESPONSE FOR  
EACH ITEM (a-f)**

17. Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? (If multiple conditions caused the death and any of the conditions were pre-existing, mark "Pre-existing medical condition.")

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

- ☒ Pre-existing medical condition  
☐ Deceased developed condition after admission  
☐ Could not be determined

Please add any additional notes regarding this death here:

Form NPS-4A  
(Addendum)
**MORTALITY IN CORRECTIONAL INSTITUTIONS 2019  
STATE PRISON INMATE  
DEATH REPORT**

 U.S. DEPARTMENT OF JUSTICE  
BUREAU OF JUSTICE STATISTICS  
AND ACTING AS COLLECTION AGENT:  
RTI INTERNATIONAL
**FORM COMPLETED BY:**

Name	<input type="text"/>	Title	<input type="text"/>
Official Address	<input type="text"/>	Telephone	<input type="text"/> <input type="text"/>
City	<input type="text"/>	FAX	<input type="text"/> <input type="text"/>
State	<input type="text"/>	Zip	<input type="text"/>
		E-mail	<input type="text"/>

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**E-MAIL:** [bjsmci@rti.org](mailto:bjsmci@rti.org)
**FAX (TOLL-FREE):** (866) 800-9179

**MAIL:** RTI International, Attn: Data Capture  
Project #: 0215015.001.300.117.102.100  
5265 Capital Boulevard  
Raleigh, NC 27690-1652

*If you need assistance, contact the data collection team at RTI International toll-free at (800) 344-1387 or [bjsmci@rti.org](mailto:bjsmci@rti.org)*
**What deaths should be reported?****INCLUDE** deaths of ALL persons...

- Confined in your correctional facilities, whether housed under your jurisdiction or that of another state
- Under your jurisdiction but housed in private correctional facilities, whether located in or out of state
- Under your jurisdiction but in special facilities (e.g., medical/treatment/release centers, halfway houses, police/court lockups, or work farms)
- In transit to or from your facilities while under your supervision

**EXCLUDE** deaths of ALL persons...

- Executed in your state
- Confined in local jail facilities, whether located in or out of state
- Under your jurisdiction but housed in a state-operated correctional facility in another state or in a federal facility
- Under probation or parole supervision in your state
- Under your jurisdiction but on AWOL or escape-status at the time of death

**BURDEN STATEMENT**

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# STATE PRISON INMATE DEATH REPORT

1. What was the inmate's name?

Foley Willie

LAST FIRST MI

2. On what date did the inmate die?

0 1 1 4 2 0 1 9

MONTH DAY YEAR

3. What was the name and location of the correctional facility involved?

Facility Name:

ELAYN HUNT CORRECTIONAL CENTER

Facility City:

SAINT GABRIEL

Facility State:

LA

4. What was the inmate's date of birth?

0 2 0 4 1 9 6 5

MONTH DAY YEAR

5. What was the inmate's sex?

- ☒ Male  
☐ Female

6. Was the inmate of Hispanic, Latino, or Spanish origin?

- ☐ Yes  
☒ No

7. In addition, what was the inmate's race? Please select one or more of the following racial categories:

- ☐ White  
☒ Black or African American  
☐ American Indian or Alaska Native  
☐ Asian  
☐ Native Hawaiian or Pacific Islander  
☐ Some other race

↳ Please Specify:

8. On what date was the inmate admitted to one of your correctional facilities?

1 2 0 7 1 9 8 1

MONTH DAY YEAR

9. For what offense(s) was the inmate being held?

a. Aggravated Rape

b.

c.

d.

e.

10. Since admission, did the inmate ever stay overnight in a mental health facility?

- ☐ Yes  
☐ No  
☒ Don't Know

11. Where did the inmate die?

- ☒ In a general housing unit in the facility or in a general housing unit on prison grounds  
☐ In a segregation unit  
☐ In a special medical unit/infirmary within your facility  
☐ In a special mental health services unit within your facility  
☐ In a medical center outside your facility  
☐ In a mental health center outside your facility  
☐ While in transit  
☐ Elsewhere

↳ Please Specify:

2. Are the results of a medical examiner's or coroner's evaluation (such as an autopsy, postmortem exam, or review of medical records) available to establish an official cause of death?

- ☒ YES → **CONTINUE TO Q13**  
☐ Evaluation complete—results are pending

→ **SKIP REMAINING QUESTIONS AND SUBMIT THIS FORM—YOU WILL BE CONTACTED AT A LATER TIME FOR THE CAUSE OF DEATH**

- ☐ No evaluation is planned → **CONTINUE TO Q13**

13. What was the cause of death? \*\*\* Please SPECIFY cause of death—it is critical information\*\*\*

- ☒ Illness—Exclude AIDS-related deaths [Specify] → Cardiac Arrest
- ☐ Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Accidental alcohol/drug intoxication [Describe] →
- ☐ Accidental injury to self [Describe] →
- ☐ Accidental injury by other (e.g., vehicular accidents during transport) [Describe] →
- ☐ Suicide (e.g., hanging, knife/cutting instrument, intentional drug overdose) [Describe] →
- ☐ Homicide [Describe] →
- ☐ Other cause(s) [Specify] →

14. Where did the incident (e.g., accident, suicide, or homicide) causing the death take place?

- ☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

- ☐ In the prison facility or on the prison grounds

[PLEASE SPECIFY]

- ☐ In the inmate's cell/room  
☐ In a temporary holding area/lockup  
☐ In a common area within the facility (e.g., yard, library, cafeteria)  
☐ In a special medical unit/infirmary  
☐ In a special mental health services unit  
☐ In a segregation unit  
☐ On death row, special unit awaiting capital punishment  
☐ Elsewhere within the prison facility

Please Specify:

- ☐ Outside the prison facility (e.g., while on work release or on work detail)

- ☐ Elsewhere

Please Specify:

15. When did the incident (e.g., accident, suicide, or homicide) causing the death occur?

- ☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

- ☐ Morning (6 am to Noon)  
☐ Afternoon (Noon to 6 pm)  
☐ Evening (6 pm to Midnight)  
☐ Overnight (Midnight to 6 am)



16. Excluding emergency care provided at the time of death, did the inmate receive any of the following medical services for the medical condition that caused his/her death after admission to your correctional facilities?

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

	YES	NO	DON'T KNOW
a. Evaluated by physician/medical staff .....	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b. Diagnostic tests (e.g., X-rays, MRI) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c. Medications .....	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d. Treatment/care other than medications .....	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
e. Surgery .....	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
f. Confinement in special medical unit .....	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

PLEASE PROVIDE A  
RESPONSE FOR  
EACH ITEM (a-f)

17. Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? (If multiple conditions caused the death and any of the conditions were pre-existing, mark "Pre-existing medical condition.")

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

☐ Pre-existing medical condition

☐ Deceased developed condition after admission

☒ Could not be determined

Please add any additional notes regarding this death here:

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**STATE PRISON INMATE**  
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State	<input type="text"/>	Zip	<input type="text"/>
		E-mail	<input type="text"/>

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- In transit to or from your facilities while under your supervision

**EXCLUDE** deaths of ALL persons...

- Executed in your state
- Confined in local jail facilities, whether located in or out of state
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# STATE PRISON INMATE DEATH REPORT

1. What was the inmate's name?

Funchess Arthur L  
LAST FIRST MI

2. On what date did the inmate die?

0 6 0 3 2 0 1 9  
MONTH DAY YEAR

3. What was the name and location of the correctional facility involved?

Facility Name:

ELAYN HUNT CORRECTIONAL CENTER

Facility City:

SAINT GABRIEL

Facility State:

LA

4. What was the inmate's date of birth?

0 2 1 3 1 9 6 2  
MONTH DAY YEAR

5. What was the inmate's sex?

- ☒ Male  
☐ Female

6. Was the inmate of Hispanic, Latino, or Spanish origin?

- ☐ Yes  
☒ No

7. In addition, what was the inmate's race? Please select one or more of the following racial categories:

- ☐ White  
☒ Black or African American  
☐ American Indian or Alaska Native  
☐ Asian  
☐ Native Hawaiian or Pacific Islander  
☐ Some other race

→ Please Specify:

8. On what date was the inmate admitted to one of your correctional facilities?

0 7 1 8 1 9 7 9  
MONTH DAY YEAR

9. For what offense(s) was the inmate being held?

a. 2nd degree murder

b.

c.

d.

e.

10. Since admission, did the inmate ever stay overnight in a mental health facility?

- ☐ Yes  
☐ No  
☒ Don't Know

11. Where did the inmate die?

- ☐ In a general housing unit in the facility or in a general housing unit on prison grounds  
☐ In a segregation unit  
☒ In a special medical unit/infirmary within your facility  
☐ In a special mental health services unit within your facility  
☐ In a medical center outside your facility  
☐ In a mental health center outside your facility  
☐ While in transit  
☐ Elsewhere

→ Please Specify:

12. Are the results of a medical examiner's or coroner's evaluation (such as an autopsy, postmortem exam, or review of medical records) available to establish an official cause of death?

- ☐ YES → **CONTINUE TO Q13**  
☐ Evaluation complete—results are pending

→ **SKIP REMAINING QUESTIONS AND SUBMIT THIS FORM—YOU WILL BE CONTACTED AT A LATER TIME FOR THE CAUSE OF DEATH**

- ☒ No evaluation is planned → **CONTINUE TO Q13**

13. What was the cause of death? \*\*\* Please SPECIFY cause of death—it is critical information\*\*\*

- ☒ Illness—Exclude AIDS-related deaths [Specify] → Liver Disease

- ☐ Acquired Immune Deficiency Syndrome (AIDS)

- ☐ Accidental alcohol/drug intoxication [Describe] →

- ☐ Accidental injury to self [Describe] →

- ☐ Accidental injury by other (e.g., vehicular accidents during transport) [Describe] →

- ☐ Suicide (e.g., hanging, knife/cutting instrument, intentional drug overdose) [Describe] →

- ☐ Homicide [Describe] →

- ☐ Other cause(s) [Specify] →

14. Where did the incident (e.g., accident, suicide, or homicide) causing the death take place?

- ☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

- ☐ In the prison facility or on the prison grounds

[PLEASE SPECIFY]

- ☐ In the inmate's cell/room  
☐ In a temporary holding area/lockup  
☐ In a common area within the facility (e.g., yard, library, cafeteria)  
☐ In a special medical unit/infirmery  
☐ In a special mental health services unit  
☐ In a segregation unit  
☐ On death row, special unit awaiting capital punishment  
☐ Elsewhere within the prison facility

→ Please Specify:

- ☐ Outside the prison facility (e.g., while on work release or on work detail)

- ☐ Elsewhere

→ Please Specify:

15. When did the incident (e.g., accident, suicide, or homicide) causing the death occur?

- ☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

- ☐ Morning (6 am to Noon)  
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16. Excluding emergency care provided at the time of death, did the inmate receive any of the following medical services for the medical condition that caused his/her death after admission to your correctional facilities?

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

	YES	NO	DON'T KNOW
a. Evaluated by physician/medical staff .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnostic tests (e.g., X-rays, MRI) .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Treatment/care other than medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Surgery .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
f. Confinement in special medical unit .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

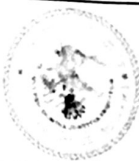
**PLEASE PROVIDE A  
RESPONSE FOR  
EACH ITEM (a-f)**

17. Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? (If multiple conditions caused the death and any of the conditions were pre-existing, mark "Pre-existing medical condition.")

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

- ☒ Pre-existing medical condition
- ☐ Deceased developed condition after admission
- ☐ Could not be determined

Please add any additional notes regarding this death here:

Form NPS-4A  
(Addendum)
**MORTALITY IN CORRECTIONAL INSTITUTIONS 2019**  
**STATE PRISON INMATE**  
**DEATH REPORT**

 U.S. DEPARTMENT OF JUSTICE  
 BUREAU OF JUSTICE STATISTICS  
 AND ACTING AS COLLECTION AGENT:  
 RTI INTERNATIONAL
**FORM COMPLETED BY:**

Name

Title

Official  
Address

Telephone



City

FAX



State

Zip

E-mail

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**EXCLUDE** deaths of ALL persons...

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# STATE PRISON INMATE DEATH REPORT

1. What was the inmate's name?

Gillespie Alvin

LAST FIRST MI

2. On what date did the inmate die?

0 3 1 9 2 0 1 9

MONTH DAY YEAR

3. What was the name and location of the correctional facility involved?

Facility Name:

ELAYN HUNT CORRECTIONAL CENTER

Facility City:

SAINT GABRIEL

Facility State:

LA

4. What was the inmate's date of birth?

0 6 0 7 1 9 6 3

MONTH DAY YEAR

5. What was the inmate's sex?

- ☒ Male  
☐ Female

6. Was the inmate of Hispanic, Latino, or Spanish origin?

- ☐ Yes  
☒ No

7. In addition, what was the inmate's race? Please select one or more of the following racial categories:

- ☐ White  
☒ Black or African American  
☐ American Indian or Alaska Native  
☐ Asian  
☐ Native Hawaiian or Pacific Islander  
☐ Some other race

→ Please Specify:

8. On what date was the inmate admitted to one of your correctional facilities?

1 0 2 5 2 0 1 6

MONTH DAY YEAR

9. For what offense(s) was the inmate being held?

- a. Second Degree Kidnapping  
b.   
c.   
d.   
e.

10. Since admission, did the inmate ever stay overnight in a mental health facility?

- ☐ Yes  
☐ No  
☒ Don't Know

11. Where did the inmate die?

- ☐ In a general housing unit in the facility or in a general housing unit on prison grounds  
☐ In a segregation unit  
☒ In a special medical unit/infirmery within your facility  
☐ In a special mental health services unit within your facility  
☐ In a medical center outside your facility  
☐ In a mental health center outside your facility  
☐ While in transit  
☐ Elsewhere

→ Please Specify:

Are the results of a medical examiner's or coroner's evaluation (such as an autopsy, postmortem exam, or review of medical records) available to establish an official cause of death?

☒ YES → **CONTINUE TO Q13**

☐ Evaluation complete—results are pending

→ **SKIP REMAINING QUESTIONS AND SUBMIT THIS FORM—YOU WILL BE CONTACTED AT A LATER TIME FOR THE CAUSE OF DEATH**

☐ No evaluation is planned → **CONTINUE TO Q13**

**13. What was the cause of death? \*\*\* Please SPECIFY cause of death—it is critical information\*\*\***

☒ Illness—Exclude AIDS-related deaths [Specify] → COPD

☐ Acquired Immune Deficiency Syndrome (AIDS)

☐ Accidental alcohol/drug intoxication [Describe] →

☐ Accidental injury to self [Describe] →

☐ Accidental injury by other (e.g., vehicular accidents during transport) [Describe] →

☐ Suicide (e.g., hanging, knife/cutting instrument, intentional drug overdose) [Describe] →

☐ Homicide [Describe] →

☐ Other cause(s) [Specify] →

**14. Where did the incident (e.g., accident, suicide, or homicide) causing the death take place?**

☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

☐ In the prison facility or on the prison grounds

[PLEASE SPECIFY]

☐ In the inmate's cell/room

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☐ In a common area within the facility (e.g., yard, library, cafeteria)

☐ In a special medical unit/infirmary

☐ In a special mental health services unit

☐ In a segregation unit

☐ On death row, special unit awaiting capital punishment

☐ Elsewhere within the prison facility

→ Please Specify:

☐ Outside the prison facility (e.g., while on work release or on work detail)

☐ Elsewhere

→ Please Specify:

**15. When did the incident (e.g., accident, suicide, or homicide) causing the death occur?**

☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

☐ Morning (6 am to Noon)

☐ Afternoon (Noon to 6 pm)

☐ Evening (6 pm to Midnight)

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16. Excluding emergency care provided at the time of death, did the inmate receive any of the following medical services for the medical condition that caused his/her death after admission to your correctional facilities?

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

	YES	NO	DON'T KNOW
a. Evaluated by physician/medical staff .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnostic tests (e.g., X-rays, MRI) .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
c. Medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Treatment/care other than medications .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
e. Surgery .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
f. Confinement in special medical unit .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

PLEASE PROVIDE A  
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17. Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? (If multiple conditions caused the death and any of the conditions were pre-existing, mark "Pre-existing medical condition.")

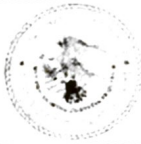
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Form NPS-4A  
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Name	<input type="text"/>	Title	<input type="text"/>
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- Under your jurisdiction but on AWOL or escape-status at the time of death

**BURDEN STATEMENT**

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# STATE PRISON INMATE DEATH REPORT

1. What was the inmate's name?

Guillory

LAST

Arthur

FIRST

MI

2. On what date did the inmate die?

0

4

MONTH

2

6

DAY

2

0

1

9

YEAR

3. What was the name and location of the correctional facility involved?

Facility Name:

ELAYN HUNT CORRECTIONAL CENTER

Facility City:

SAINT GABRIEL

Facility State:

LA

4. What was the inmate's date of birth?

0

9

MONTH

2

7

DAY

1

9

4

2

YEAR

5. What was the inmate's sex?

☒ Male

☐ Female

6. Was the inmate of Hispanic, Latino, or Spanish origin?

☐ Yes

☒ No

7. In addition, what was the inmate's race? Please select one or more of the following racial categories:

☐ White

☒ Black or African American

☐ American Indian or Alaska Native

☐ Asian

☐ Native Hawaiian or Pacific Islander

☐ Some other race

Please Specify:

8. On what date was the inmate admitted to one of your correctional facilities?

0

4

MONTH

2

6

DAY

1

9

7

3

YEAR

9. For what offense(s) was the inmate being held?

a. Second Degree Murder

b.

c.

d.

e.

10. Since admission, did the inmate ever stay overnight in a mental health facility?

☐ Yes

☐ No

☒ Don't Know

11. Where did the inmate die?

☐ In a general housing unit in the facility or in a general housing unit on prison grounds

☐ In a segregation unit

☒ In a special medical unit/infirmary within your facility

☐ In a special mental health services unit within your facility

☐ In a medical center outside your facility

☐ In a mental health center outside your facility

☐ While in transit

☐ Elsewhere

Please Specify:

are the results of a medical examiner's or coroner's evaluation (such as an autopsy, postmortem exam, or review of medical records) available to establish an official cause of death?

☐ YES → **CONTINUE TO Q13**

☐ Evaluation complete—results are pending

→ **SKIP REMAINING QUESTIONS AND SUBMIT THIS FORM—YOU WILL BE CONTACTED AT A LATER TIME FOR THE CAUSE OF DEATH**

☒ No evaluation is planned → **CONTINUE TO Q13**

**13. What was the cause of death? \*\*\* Please SPECIFY cause of death—it is critical information\*\*\***

☒ Illness—Exclude AIDS-related deaths [Specify] → Cardiorespiratory arrest due to end stage de

☐ Acquired Immune Deficiency Syndrome (AIDS)

☐ Accidental alcohol/drug intoxication [Describe] →

☐ Accidental injury to self [Describe] →

☐ Accidental injury by other (e.g., vehicular accidents during transport) [Describe] →

☐ Suicide (e.g., hanging, knife/cutting instrument, intentional drug overdose) [Describe] →

☐ Homicide [Describe] →

☐ Other cause(s) [Specify] →

**14. Where did the incident (e.g., accident, suicide, or homicide) causing the death take place?**

☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

☐ In the prison facility or on the prison grounds

[PLEASE SPECIFY]

☐ In the inmate's cell/room

☐ In a temporary holding area/lockup

☐ In a common area within the facility (e.g., yard, library, cafeteria)

☐ In a special medical unit/infirmery

☐ In a special mental health services unit

☐ In a segregation unit

☐ On death row, special unit awaiting capital punishment

☐ Elsewhere within the prison facility

Please Specify:

☐ Outside the prison facility (e.g., while on work release or on work detail)

☐ Elsewhere

Please Specify:

**15. When did the incident (e.g., accident, suicide, or homicide) causing the death occur?**

☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

☐ Morning (6 am to Noon)

☐ Afternoon (Noon to 6 pm)

☐ Evening (6 pm to Midnight)

☐ Overnight (Midnight to 6 am)



16. Excluding emergency care provided at the time of death, did the inmate receive any of the following medical services for the medical condition that caused his/her death after admission to your correctional facilities?

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

	YES	NO	DON'T KNOW
a. Evaluated by physician/medical staff .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnostic tests (e.g., X-rays, MRI) .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Treatment/care other than medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Surgery .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
f. Confinement in special medical unit .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PLEASE PROVIDE A  
RESPONSE FOR  
EACH ITEM (a-f)**

17. Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? (If multiple conditions caused the death and any of the conditions were pre-existing, mark "Pre-existing medical condition.")

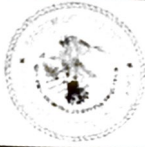
☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

☐ Pre-existing medical condition

☒ Deceased developed condition after admission

☐ Could not be determined

Please add any additional notes regarding this death here:

Form NPS-4A  
(Addendum)
**MORTALITY IN CORRECTIONAL INSTITUTIONS 2019**  
**STATE PRISON INMATE**  
**DEATH REPORT**

 U.S. DEPARTMENT OF JUSTICE  
 BUREAU OF JUSTICE STATISTICS  
 AND ACTING AS COLLECTION AGENT:  
 RTI INTERNATIONAL
**FORM COMPLETED BY:**

Name	<input type="text"/>	Title	<input type="text"/>
Official Address	<input type="text"/>	Telephone	<input type="text"/>
City	<input type="text"/>	FAX	<input type="text"/>
State	<input type="text"/>	Zip	<input type="text"/>
		E-mail	<input type="text"/>

**Instructions for Completion**If no deaths occurred in 2019:

- You do not need to complete this form.

If you had more than one death in 2019:

- Make copies of this form for each additional death.
- Complete the entire form for each inmate death.
- Once your death records are complete, there are several ways to submit a death report:

**ONLINE:** Complete the report online at: <https://bjsmci.rti.org>
**MAIL:** RTI International, Attn: Data Capture  
 Project #: 0215015.001.300.117.102.100  
 5265 Capital Boulevard  
 Raleigh, NC 27690-1652

**E-MAIL:** [bjsmci@rti.org](mailto:bjsmci@rti.org)
**FAX (TOLL-FREE):** (866) 800-9179

*If you need assistance, contact the data collection team at RTI International toll-free at (800) 344-1387 or [bjsmci@rti.org](mailto:bjsmci@rti.org)*
**What deaths should be reported?**INCLUDE deaths of ALL persons...

- Confined in your correctional facilities, whether housed under your jurisdiction or that of another state
- Under your jurisdiction but housed in private correctional facilities, whether located in or out of state
- Under your jurisdiction but in special facilities (e.g., medical/treatment/release centers, halfway houses, police/court lockups, or work farms)
- In transit to or from your facilities while under your supervision

EXCLUDE deaths of ALL persons...

- Executed in your state
- Confined in local jail facilities, whether located in or out of state
- Under your jurisdiction but housed in a state-operated correctional facility in another state or in a federal facility
- Under probation or parole supervision in your state
- Under your jurisdiction but on AWOL or escape-status at the time of death

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# STATE PRISON INMATE DEATH REPORT

1. What was the inmate's name?

Harmanson Willie

LAST FIRST MI

2. On what date did the inmate die?

0 8 2 0 2 0 1 9

MONTH DAY YEAR

3. What was the name and location of the correctional facility involved?

Facility Name:

ELAYN HUNT CORRECTIONAL CENTER

Facility City:

SAINT GABRIEL

Facility State:

LA

4. What was the inmate's date of birth?

0 3 0 4 1 9 6 7

MONTH DAY YEAR

5. What was the inmate's sex?

- ☒ Male  
☐ Female

6. Was the inmate of Hispanic, Latino, or Spanish origin?

- ☐ Yes  
☒ No

7. In addition, what was the inmate's race? Please select one or more of the following racial categories:

- ☐ White  
☒ Black or African American  
☐ American Indian or Alaska Native  
☐ Asian  
☐ Native Hawaiian or Pacific Islander  
☐ Some other race

→ Please Specify:

8. On what date was the inmate admitted to one of your correctional facilities?

0 4 1 2 2 0 1 9

MONTH DAY YEAR

9. For what offense(s) was the inmate being held?

a. Sex Offender Register Violation

b.

c.

d.

e.

10. Since admission, did the inmate ever stay overnight in a mental health facility?

- ☐ Yes  
☐ No  
☒ Don't Know

11. Where did the inmate die?

- ☐ In a general housing unit in the facility or in a general housing unit on prison grounds  
☐ In a segregation unit  
☐ In a special medical unit/infirmery within your facility  
☐ In a special mental health services unit within your facility  
☒ In a medical center outside your facility  
☐ In a mental health center outside your facility  
☐ While in transit  
☐ Elsewhere

→ Please Specify:

12. Are the results of a medical examiner's or coroner's evaluation (such as an autopsy, postmortem exam, or review of medical records) available to establish an official cause of death?

☐ YES → **CONTINUE TO Q13**

☐ Evaluation complete—results are pending

→ **SKIP REMAINING QUESTIONS AND SUBMIT THIS FORM—YOU WILL BE CONTACTED AT A LATER TIME FOR THE CAUSE OF DEATH**

☒ No evaluation is planned → **CONTINUE TO Q13**

13. What was the cause of death? \*\*\* Please SPECIFY cause of death—it is critical information\*\*\*

☒ Illness—Exclude AIDS-related deaths [Specify] → Cancer

☐ Acquired Immune Deficiency Syndrome (AIDS)

☐ Accidental alcohol/drug intoxication [Describe] →

☐ Accidental injury to self [Describe] →

☐ Accidental injury by other (e.g., vehicular accidents during transport) [Describe] →

☐ Suicide (e.g., hanging, knife/cutting instrument, intentional drug overdose) [Describe] →

☐ Homicide [Describe] →

☐ Other cause(s) [Specify] →

14. Where did the incident (e.g., accident, suicide, or homicide) causing the death take place?

☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

☐ In the prison facility or on the prison grounds

(PLEASE SPECIFY)

☐ In the inmate's cell/room

☐ In a temporary holding area/lockup

☐ In a common area within the facility (e.g., yard, library, cafeteria)

☐ In a special medical unit/infirmarv

☐ In a special mental health services unit

☐ In a segregation unit

☐ On death row, special unit awaiting capital punishment

☐ Elsewhere within the prison facility

→ Please Specify:

☐ Outside the prison facility (e.g., while on work release or on work detail)

☐ Elsewhere

→ Please Specify:

15. When did the incident (e.g., accident, suicide, or homicide) causing the death occur?

☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

☐ Morning (6 am to Noon)

☐ Afternoon (Noon to 6 pm)

☐ Evening (6 pm to Midnight)

☐ Overnight (Midnight to 6 am)



16. Excluding emergency care provided at the time of death, did the inmate receive any of the following medical services for the medical condition that caused his/her death after admission to your correctional facilities?

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

	YES	NO	DON'T KNOW
a. Evaluated by physician/medical staff .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnostic tests (e.g., X-rays, MRI) .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Treatment/care other than medications .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
e. Surgery .....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
f. Confinement in special medical unit .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

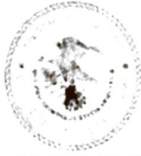
**PLEASE PROVIDE A  
RESPONSE FOR  
EACH ITEM (a-f)**

17. Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? (If multiple conditions caused the death and any of the conditions were pre-existing, mark "Pre-existing medical condition.")

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

- ☒ Pre-existing medical condition  
☐ Deceased developed condition after admission  
☐ Could not be determined

Please add any additional notes regarding this death here:

Form NPS-4A  
(Addendum)
**MORTALITY IN CORRECTIONAL INSTITUTIONS 2019**  
**STATE PRISON INMATE**  
**DEATH REPORT**

 U.S. DEPARTMENT OF JUSTICE  
 BUREAU OF JUSTICE STATISTICS  
 AND ACTING AS COLLECTION AGENT:  
 RTI INTERNATIONAL
**FORM COMPLETED BY:**

Name	<input type="text"/>	Title	<input type="text"/>
Official Address	<input type="text"/>	Telephone	<input type="text"/>
City	<input type="text"/>	FAX	<input type="text"/>
State	<input type="text"/>	Zip	<input type="text"/>
		E-mail	<input type="text"/>

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- You do not need to complete this form.

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**E-MAIL:** [bjsmci@rti.org](mailto:bjsmci@rti.org)
**FAX (TOLL-FREE):** (866) 800-9179

**MAIL:** RTI International, Attn: Data Capture  
 Project #: 0215015.001.300.117.102.100  
 5265 Capital Boulevard  
 Raleigh, NC 27690-1652

*If you need assistance, contact the data collection team at RTI International toll-free at (800) 344-1387 or [bjsmci@rti.org](mailto:bjsmci@rti.org)*
**What deaths should be reported?****INCLUDE** deaths of ALL persons...

- Confined in your correctional facilities, whether housed under your jurisdiction or that of another state
- Under your jurisdiction but housed in private correctional facilities, whether located in or out of state
- Under your jurisdiction but in special facilities (e.g., medical/treatment/release centers, halfway houses, police/court lockups, or work farms)
- In transit to or from your facilities while under your supervision

**EXCLUDE** deaths of ALL persons...

- Executed in your state
- Confined in local jail facilities, whether located in or out of state
- Under your jurisdiction but housed in a state-operated correctional facility in another state or in a federal facility
- Under probation or parole supervision in your state
- Under your jurisdiction but on AWOL or escape-status at the time of death

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# STATE PRISON INMATE DEATH REPORT

1. What was the inmate's name?

Henry Cornell R  
LAST FIRST MI

2. On what date did the inmate die?

0 7 0 2 2 0 1 9  
MONTH DAY YEAR

3. What was the name and location of the correctional facility involved?

Facility Name:

ELAYN HUNT CORRECTIONAL CENTER

Facility City:

SAINT GABRIEL

Facility State:

LA

4. What was the inmate's date of birth?

1 2 2 8 1 9 6 5  
MONTH DAY YEAR

5. What was the inmate's sex?

- ☒ Male  
☐ Female

6. Was the inmate of Hispanic, Latino, or Spanish origin?

- ☐ Yes  
☒ No

7. In addition, what was the inmate's race? Please select one or more of the following racial categories:

- ☐ White  
☒ Black or African American  
☐ American Indian or Alaska Native  
☐ Asian  
☐ Native Hawaiian or Pacific Islander  
☐ Some other race

Please Specify:

8. On what date was the inmate admitted to one of your correctional facilities?

0 6 1 3 2 0 1 6  
MONTH DAY YEAR

9. For what offense(s) was the inmate being held?

- a. Attempted First Degree Murder  
b.  
c.  
d.  
e.

10. Since admission, did the inmate ever stay overnight in a mental health facility?

- ☐ Yes  
☐ No  
☒ Don't Know

11. Where did the inmate die?

- ☐ In a general housing unit in the facility or in a general housing unit on prison grounds  
☐ In a segregation unit  
☐ In a special medical unit/infirmery within your facility  
☐ In a special mental health services unit within your facility  
☒ In a medical center outside your facility  
☐ In a mental health center outside your facility  
☐ While in transit  
☐ Elsewhere

Please Specify:

the results of a medical examiner's or coroner's evaluation (such as an autopsy, postmortem exam, or view of medical records) available to establish an official cause of death?

- ☐ YES → CONTINUE TO Q13
- ☐ Evaluation complete—results are pending

→ SKIP REMAINING QUESTIONS AND SUBMIT THIS FORM—YOU WILL BE CONTACTED AT A LATER TIME FOR THE CAUSE OF DEATH

☒ No evaluation is planned → CONTINUE TO Q13

13. What was the cause of death?

\*\*\* Please SPECIFY cause of death—it is critical information\*\*\*

- ☒ Illness—Exclude AIDS-related deaths [Specify] → Liver Disease
- ☐ Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Accidental alcohol/drug intoxication [Describe] →
- ☐ Accidental injury to self [Describe] →
- ☐ Accidental injury by other (e.g., vehicular accidents during transport) [Describe] →
- ☐ Suicide (e.g., hanging, knife/cutting instrument, intentional drug overdose) [Describe] →
- ☐ Homicide [Describe] →
- ☐ Other cause(s) [Specify] →

14. Where did the incident (e.g., accident, suicide, or homicide) causing the death take place?

- ☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related

- ☐ In the prison facility or on the prison grounds
  - ☐ In the inmate's cell/room
  - ☐ In a temporary holding area/lockup
  - ☐ In a common area within the facility (e.g., yard, library, cafeteria)
  - ☐ In a special medical unit/infirmary
  - ☐ In a special mental health services unit
  - ☐ In a segregation unit
  - ☐ On death row, special unit awaiting capital punishment
  - ☐ Elsewhere within the prison facility

[PLEASE SPECIFY]

Please Specify:

- ☐ Outside the prison facility (e.g., while on work release or on work detail)
- ☐ Elsewhere

Please Specify:

15. When did the incident (e.g., accident, suicide, or homicide) causing the death occur?

- ☒ NOT APPLICABLE—Cause of death was illness, intoxication, or AIDS-related
- ☐ Morning (6 am to Noon)
- ☐ Afternoon (Noon to 6 pm)
- ☐ Evening (6 pm to Midnight)
- ☐ Overnight (Midnight to 6 am)



**16. Excluding emergency care provided at the time of death, did the inmate receive any of the following medical services for the medical condition that caused his/her death after admission to your correctional facilities?**

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

	YES	NO	DON'T KNOW
a. Evaluated by physician/medical staff .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnostic tests (e.g., X-rays, MRI) .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Treatment/care other than medications .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Surgery .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Confinement in special medical unit .....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PLEASE PROVIDE A  
RESPONSE FOR  
EACH ITEM (a-f)**

**17. Was the cause of death the result of a pre-existing medical condition or did the inmate develop the condition after admission? (If multiple conditions caused the death and any of the conditions were pre-existing, mark "Pre-existing medical condition.")**

☐ NOT APPLICABLE—Cause of death was accidental injury, intoxication, suicide, or homicide

☒ Pre-existing medical condition

☐ Deceased developed condition after admission

☐ Could not be determined

*Please add any additional notes regarding this death here:*