Institutional Failure in the Life Histories of Men Condemned to Death

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The literature on capital murder defendants sentenced to death documents organic and functional mental problems in many of them,[1–4] but only one paper discusses the role of social institutions in the lives of these people prior to their convictions.[5] This article reviews the case histories of 16 death row inmates, focusing on the relationship between the problems they demonstrated and the institutional response to those problems. By focusing exclusively on the individual, prior research has implied that the character of the defendant and the circumstances of the crime are sufficient to understand lethal violence. However, if institutional failure combines with individual psychopathology, this implies that social response as well as individual pathology contribute to cases of lethal violence that lead to a death sentence.

Patterns of institutional failure among men sentenced to death began to become apparent based on postconviction investigative work undertaken in California by one of the authors (D.F.). The 16 cases reported here, an admittedly small sample of death row clients, came from a capital resource center. The selection of this sample was based on urgency, meaning that clients closest to execution received investigative assistance first. Although this is not a random-sampling process, there is no reason to believe that this selection process would have tended to overselect for institutional failure or psychiatric impairment. Review of the trial records suggests that the character of the men and the circumstances of the killings in these cases are not distinguishable from the broad range of cases that receive death sentences in California.

Data are drawn from interviews with family members, friends, ex-lovers, neighbors, teachers, coworkers, former crime partners, cell-mates from prior incarcerations, prior attorneys, doctors, social workers, probation officers, police officers, and victims of prior crimes. Criminal justice, school, medical, and social service records also were reviewed. In every case, information obtained in interviews was corroborated by institutional records

The group of 16 men was 56% white, 25% black, and 19% Mexican-American, compared with the group consisting of all men on death row in California (as of 1998), which was 43% white, 36% black, 15% Mexican-American, and 4% other races.[6] Men in the sample were born between 1945 and 1962. The homicides for which they are on death row and their trials occurred between 1977 and 1987, the first 10 years following the reintroduction of the death penalty in California. Two men in the sample have been executed, four have had their sentences reversed on appeal, and one died on death row while his appeal was pending. The rest are awaiting review of their cases in federal court.

The life histories of these 16 men document substantial family violence and individual psychiatric and neurologic deficits in all cases. Fourteen were victims of severe and chronic physical and/or sexual abuse, including three who were beaten unconscious. Seven of the 14 targeted boys were singled out because they suffered from mental illness or impairment, and two because their fathers suspected they

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were illegitimate. Fifteen witnessed repeated, severe family and/or community violence. Fourteen have been diagnosed with posttraumatic stress disorder after undergoing repeated life-threatening assault. Other diagnoses included the following: traumatic brain injury (12), with multiple, independent traumatic head injuries in 7 of these 12 cases; mental retardation, functional mental retardation, or borderline mental retardation (10); depression (13); polysubstance abuse (13); and psychosis (9).[7]

Institutional Responses

These men had repeated contacts throughout their lives with social institutions charged with providing care for them: schools, prisons, juvenile detention facilities, foster homes, and medical and psychiatric facilities. In 15 cases, the evidence pointed strongly to substantial institutional failure both to recognize and address the problems. Here, we distinguish individual from institutional response. In many cases, individual physicians or teachers struggled against the impediments of the institution to provide care.

Schools failed nine men. Mr. N. was initially unable to qualify for recommended special education placement because his family could not afford the required preplacement medical examination. When he was placed in special education, his school records indicate that "[Mr. N] is working with the Learning Disabilities teacher. She states that [he] is too far behind for the materials she has." After 12 years of social promotion, N. was illiterate. Five other men with comparable histories of failed special education placements also were illiterate. Three of those five were subsequently re-enrolled in standard classes, despite the recommendation of individual teachers to maintain them in special education classes.

Mr. M.'s teacher believed that M. was in need of a psychiatric referral, but none was available. M. fled his physically abusive home, taking a gun with him to protect himself on the streets. He carried the gun to school and asked the teacher to hold it for him. The teacher viewed this as a cry for help, but the principal called the police. M. was arrested and taken into juvenile custody where he was repeatedly physically abused.

Prisons, detention facilities, and foster homes failed 12 men. Three men were sexually abused as adolescents while in the care of a juvenile facility. Mr. J. was sexually molested by older boys at a juvenile detention facility. One of the staff offered him protection from the sexual assaults, but in return, J. was required to submit to sex with this counselor over an extended period of time.

At age 18, Mr. G. was incarcerated in an adult facility. There he was "bought" and sexually enslaved by an older, bigger inmate. Prison staff were well aware of both the general conditions of inmates being bought and sold at the prison as well as the specific actions in this instance. The inmate who bought G. was notorious at the facility for identical behavior with other inmates. Yet, at no time during G.'s incarceration at this facility did anyone attempt to intervene. In fact, prison officials reported that during this time period, they had conceded regions within the prison to the inmates and relied on those inmates to control housing assignments and all other activities within those areas of the facility.

At the age of 14, Mr. D. was abandoned by his family in a field where the family had been working picking crops. He was subsequently arrested with two other juveniles for stealing a car and driving across state lines. The two other juveniles were released into the custody of their parents. Lacking a family, D. was incarcerated in federal custody from age 15 until he was almost 20. He was rearrested within months of his discharge from prison.

Six men were physically or sexually abused by foster families.

Medical and psychiatric facilities failed to address mental illness and substance abuse problems in 10 cases. Mr. P.'s juvenile facility recommended psychiatric hospitalization, but no beds were available. Mr. A. received no rehabilitation after a lobotomy. His wife, with no training, tried to retrain him in tying his shoes, eating, showering, and basic language skills. Fearing a loss of control, A. sought mental health services unsuccessfully over a three-year period.

A state mental hospital treated Mr. C. as a juvenile and returned him to court recommending residential placement, which never occurred. C. was returned to his physically and sexually abusive family where he became increasingly depressed and suicidal.

As an adult, Mr. K. twice sought psychiatric help in controlling his violence toward the woman with whom he lived. Upon intake, he was diagnosed with "emotional instability and manic rages" and possible temporal lobe epilepsy. He was prescribed Haldol but was given no psychosocial treatment. After run-

ning out of Haldol, K. returned for a refill prescription, but it was denied and he was turned away.

Following an arrest, Mr. I. received a court-ordered psychiatric evaluation. He had an extensive history of physical and sexual abuse, and he had an organic mood disorder, combat-related posttraumatic stress disorder, cerebral palsy, an abnormal electroencephalogram, and was a polysubstance abuser. There was no psychiatric recommendation for treatment. The judge, disagreeing with the evaluation, sent I. to jail with an order that he be given psychiatric treatment, but none was available.

Comment

The evidence of institutional failure across the lives of these men is pervasive. Instead of offering safety, these institutions often placed the men whom they were charged with assisting at additional risk. Juvenile detention, prisons, and foster care exposed these men to further violence. Schools and medical facilities often failed to provide core essential services.

Although the small number of cases, the lack of a comparison group, and the nonrandom sampling limit the degree of generalizing from our report, the patterns of institutional failure suggest that further, more systematic study is warranted. For us, these cases raise questions about the fairness of executing people who have been signally failed by the larger society and the institutions charged with assisting them. These men are responsible for the murders they committed. However, it appears that society has imposed its most draconian penalty in part as a result of its own earlier institutional failures.

The question remains: are we committed strongly enough to preventing lethal violence that we will review, alter, and evaluate the institutional failures that are pervasive here? If prevention and intervention policies are to be successful, they must address not only individual pathology but also these institutional failures.

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