

**ALASKA STATE LEGISLATURE
HOUSE JUDICIARY STANDING COMMITTEE**

March 31, 2025

1:04 p.m.

MEMBERS PRESENT

Representative Andrew Gray, Chair
Representative Chuck Kopp, Vice Chair
Representative Ted Eischeid
Representative Genevieve Mina
Representative Sarah Vance
Representative Mia Costello
Representative Jubilee Underwood

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

PRESENTATION(S): INMATE DEATHS IN CUSTODY

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

ROBIN FARMER, representing self
Fairbanks, Alaska

POSITION STATEMENT: Gave invited testimony during the Inmate Deaths in Custody presentation.

ALAINA ZIMMERMAN, representing self
Seward, Alaska

POSITION STATEMENT: Gave invited testimony during the Inmate Deaths in Custody presentation.

ADAM RUTHERFORD, Deputy Director
Division of Health and Rehab Services
Department of Corrections
Anchorage, Alaska

POSITION STATEMENT: Co-offered the Inmate Deaths in Custody presentation.

TIM BALLARD, MD, Chief Medical Officer
Department of Corrections
Anchorage, Alaska

POSITION STATEMENT: Co-offered the Inmate Deaths in Custody presentation.

ZANE NIGHSWONGER, Director
Division of Institutions
Department of Corrections
Juneau, Alaska

POSITION STATEMENT: Co-offered the Inmate Deaths in Custody presentation.

LIEUTENANT RONALD HAYES, Deputy Commander
Alaska Bureau of Investigations
Alaska State Trooper
Department of Public Safety
Anchorage, Alaska

POSITION STATEMENT: Co-offered the Inmate Deaths in Custody presentation.

ALYCIA WELCH, Associate Director
Prison and Jail Innovation Lab
University of Texas
Austin, Texas

POSITION STATEMENT: Co-offered the Inmate Deaths in Custody presentation.

ACTION NARRATIVE

[1:04:46 PM](#)

CHAIR ANDREW GRAY called the House Judiciary Standing Committee meeting to order at 1:04 p.m. Representatives Kopp, Eischeid, Mina, Vance, Costello, Underwood, and Gray were present at the call to order.

REPRESENTATIVE VANCE stated that she misspoke during a previous hearing on HB 118 in response to public testimony on human trafficking. She clarified that the advocacy group in question was in support of her legislation that changed the term "child pornography" to "child sexual abuse material (CSAM)" and said she wants to respect everyone's opportunity to provide public testimony whether she agrees or disagrees.

CHAIR GRAY clarified that the organization in question does not support the legalization of prostitution. He pointed out that members of the committee are not working from a script and therefore, may misspeak or say something inaccurate; however, what matters most is their commitment to getting it right. He said clarifying statements are always welcome.

PRESENTATION(S): Inmate Deaths in Custody

[1:07:31 PM](#)

CHAIR GRAY announced that the only order of business would be the Inmate Deaths in Custody presentation and gave the following prepared remarks:

Since 2022, our state has seen a spike in deaths in custody. That year alone, the Department of Corrections reported 18 in-custody deaths, the highest number in over 20 years.

Since 2020, at least 67 individuals have died while in DOC custody. Of those, 17 were suicides. These numbers aren't just statistics—they're people. And the trends behind these deaths are especially alarming.

We have seen a disproportionate number of young people dying. Of the 36 deaths reported since 2022, 14 individuals were under the age of 40. Six were in their 20s. Many were still awaiting their day in court or held on technical violations for nonviolent offenses.

In just the first 15 days of 2024, three inmates died, nearly a third of all the deaths recorded in custody the year before. This shows us that our system is not working the way it is intended to.

In addition to the deaths, there is a serious issue with how these deaths have been reported. Reports show that the Department of Corrections does not consistently include deaths that happen in hospitals—even when they result from medical emergencies that started while a person was in DOC custody. That raises real concerns about transparency and accountability.

We owe it to the people of Alaska—to their families, their communities, and to justice itself—to take a hard look at what’s happening behind these numbers. This conversation today is the first step in a series of steps that this committee will take to ensure that things turn around and that people in our custody are safe.

[1:09:20 PM](#)

The committee took a brief at-ease at 1:09 p.m.

[1:09:58 PM](#)

CHAIR GRAY noted that a photo had been distributed to the committee at the request of one of the testifiers. He introduced Robin Farmer, the sister of William Farmer. William Farmer Died in 2025 while in custody of the Department of Corrections. In December of 2024, less than 24 hours after being placed in a cell with 2 other inmates, William Farmer was severely assaulted by another inmate. Mr. Farmer was transferred to Providence Alaska Medical Center, where he remained in critical condition until he passed.

[1:11:11 PM](#)

ROBIN FARMER, representing self, shared William Farmer’s story. She said Mr. Farmer was murdered by his cellmate while in custody at the Anchorage Correctional Complex. Mr. Farmer had been diagnosed with paranoid schizophrenia in his mid-twenties and arrested after a series of shoplifting incidents. She shared her experience with the Department of Corrections (DOC) while Mr. Farmer was being treated in Providence Alaska Medical Center, where she was subsequently banned from visitation. She said the hospital staff later remarked at DOC's inhumane treatment of Mr. Farmer and cruel behavior towards his family. After three weeks in the hospital with no changes in his condition, Mr. Farmer's family had to make the traumatic decision to take him off life support. William Farmer died three days later on January 6, 2025. Three months later, the application for burial assistance still sits at the Division of Public Assistance awaiting processing.

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ALAINA ZIMMERMAN, representing self, shared Mr. Zimmerman's story from written testimony [included in the committee packet], which read as follows [original punctuation provided]:

I am writing this letter on behalf of my brother, Joshua Keith Zimmerman. Joshua was murdered in Anchorage while in Alaska DOC custody in the early hours of January 12th, 2024.

I remember this morning so vividly. I woke up like any other day. I received a text from my mom shortly after waking up that I needed to call her and my dad as soon as possible. Hearing a parent hardly able to breathe over the loss of their child is something you will remember forever. Those first couple of weeks after Joshua's death were filled with empty words and carelessness almost as if Anchorage DOC did not care and to them it was just another inmate. But we still had hope.

Over the course of the last 9 months we have had zero answers. What we do know, or at least, what we were told by the Alaska State troopers per the Alaska State Medical Examiner is Joshua was suffocated with a soft object in his cell. He was found in his bed the following morning. Alaska DOC said foul play was "not suspected" and his cause of death was "unknown". But how could that be if he was murdered in your jail as told to us by AST? These are conflicting stories. Joshua had recently undergone a procedure amputating his foot that had been giving him trouble for years. So not only was he murdered under Anchorage Correctional Complex cameras, he was somewhat defenseless considering he was learning his new normal of using one foot to get around until he got his prosthetic. It seems a bit odd that with a building with so much security and cameras that no one can give us a straight answer. Besides the obvious fact that these correctional officers failed miserably at their job of simply keeping the inmates alive, it begs the question of who are these people protecting? We were told by the Alaska State Troopers to not speak of this heinous crime. Not speak of my brother being murdered in state custody? Who does that benefit? I understand the logistics of keeping cases private while they are being investigated but to not give us anything for months while simultaneously telling us to not speak

about it? I feel strongly that this case is being swept under the rug in hopes our family will forget and move on. Just as they have done to many others.

There are cases upon cases of Alaska DOC negligence available for public consumption online. When the Anchorage

daily newspaper wrote an article on my brother they made sure to list his charges before saying he had "passed away" in Anchorage DOC. They made sure to dehumanize my brother the best they could so the public wouldn't raise an eyebrow as to what is actually happening inside the Alaska prison system. Just as they have done to so many others.

I'm not blind to the fact that there are terrible people sitting in jails. But there are good people in them too. And frankly, the type of person you are does not give someone the right to take your life. Joshua was an avid fisherman and loved his family. I could give so many examples of Joshua helping someone in need. He had dreams of becoming a father and loved watching any sport. His heart was huge. Joshua was only 13 months older than me. He was there for me the day I took my first breath and saw me through 32 years of life. My only wish is I was there for Joshua when someone in the Anchorage correctional complex took Joshua's last breath.

Just the fact that someone is walking the streets who murdered my brother should seriously concern you. They could be your neighbor. They could be your tenant or your landlord. They could be the person pumping gas next to you or the person in the booth next to you at a restaurant celebrating their children's birthday. And they are free, with no remorse and no consequences for taking Joshua's life.

Joshua isn't the only person who has died in Alaska's jail system under unusual circumstances. Most of these cases go cold because they tell the families the same thing they have been telling us. Joshua was in jail for two misdemeanor charges. After a couple of years Joshua found himself making bad choices and decided enough was enough. He turned himself in to Alaska DOC December 12, 2023 in hopes to use the facility as a

source of rehabilitation. Isn't that the intended use of jails? If not to rehabilitate humans then what are they for? We need compassion and treatment. Mental health and addictions have no place in jails.

I have personally witnessed in my lifetime a police department solve a murder with no real leads in my home town in a span of just a few months. So please tell me why this case is over a year old with no real answers when the entire crime was in a heavily "secured" building with cameras? What is the Anchorage DOC protecting and why?

The pain the Alaska DOC has placed on my family is indescribable. While we sit with an emptiness so big as they just continue their everyday lives.

I am writing this letter on behalf of my brother and so many others who were wrongfully killed at these correctional facilities across the state of Alaska. In hopes to not only bring awareness to what is going on behind closed doors but to seek justice as well. There is a serious problem happening here and this will continue until something is done. There are pages of proof against Anchorage DOC and the lies they tell families regarding the deaths of their loved ones. Please tell me why you are funding facilities that essentially give people a safe space to murder humans? Please just imagine someone you love dying in their facility and they treat your loved one less than human.

Alaska DOC also listed my brother as an Alaskan Native. My brother and I are both 1/16 Alaskan Native. And while yes, we are proud of where we come from. I do not think his heritage being listed was anything more than a manipulation tactic. When our biological mother died she was listed as "white" and she was twice as much Aleut as my brother and I. How does that make sense? There is right and there is wrong.

Joshua Keith Zimmerman was a son, a brother, an uncle and a friend. Joshua was alive. He was right here breathing the same air as you and me. It's so hard to explain to someone what the loss of a sibling does to you. He was my first best friend. He had his whole life ahead of him and now we will never get to see it.

He was so much more than a statistic and he was so much more than the person Alaska DOC is trying to reduce him down to. Life wasn't fair to him and now, even in death, it continues to be unfair. Joshua was the man who loved to read and write. He was the teenager who got straight A's without trying. He was the little boy who walked around with a lightsaber and walked his little sister down the church steps. Joshua was an amazing person and all who knew him could tell you about his infectious smile and laugh. He was so loved. I will miss him for the rest of my life. For the rest of my life my father won't have a son. For the rest of my life I won't have a brother and my daughters won't have an uncle. He will be photos in an album and a brief 5 second clip I have of him singing his favorite song. He will never again be home for the holidays or call me just to chat. That is real pain.

I hope that one day we will find out exactly what happened to my brother in the early hours of January 12th, 2024 in Anchorage DOC custody

CHAIR GRAY asked how old Mr. Zimmerman was when he passed.

MS. ZIMMERMAN answered 33.

[1:28:39 PM](#)

ADAM RUTHERFORD, Deputy Director, Division of Health and Rehab Services, Department of Corrections (DOC), acknowledged the sensitivity of the information being presented today and the impact it has on everyone involved.

[1:29:22 PM](#)

TIM BALLARD, MD, Chief Medical Officer (CMO), Department of Corrections (DOC), summarized his professional background and noted that DOC provided a presentation on inmate deaths in custody over the past decade to the House State Affairs Standing Committee. That PowerPoint is included in the committee packet. He noted that DOC does not investigate inmate deaths, and instead, notifies the appropriate legal authorities and cooperates with them as they see fit. Separately, administrative reviews of these events are conducted for the purpose of quality improvement.

[1:30:50 PM](#)

ZANE NIGHSWONGER, Director, Division of Institutions, Department of Corrections (DOC), noted that policy 104.04 guides the department through prisoner deaths and is available to the public on DOC's website. He summarized some of the steps outlined in DOC's policy, including securing the scene; evidence collection and preservation; and a personal property inventory.

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MR. RUTHFORD discussed the department's administrative review process, which is focused on continuous quality improvement. He said internal investigations would not provide enough transparency, so the Alaska State Troopers (AST) took on that responsibility to offer a third-party, independent review of the incidents. The administrative reviews focus on the department's immediate response to the incident, the environment surrounding the incident, what went well or could be improved upon, and what might prevent future incidents from occurring.

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MR. BALLARD explained that immediately following an incident, the superintendent contacts the AST, and medical staff notifies the chief medical officer (CMO) who then reviews the medical record and relays pertinent information to the State Medical Examiner's Office.

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MR. NIGHSWONGER discussed the process of notifying next of kin and releasing the prisoner's personal property.

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MR. BALLARD spoke to the classification of deaths that occur within custody. He said a death occurring after being released from custody are not reported by DOC, as the department lacks the legal or medical authority to gather that information. The decision to release an inmate from custody while hospitalized can occur for a myriad of reasons and ultimately, lies with the Board of Parole.

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MR. NIGHSWONGER shared a historical perspective on institutional safety and risk management, as well as the creation of the

population management team whose responsibilities were focused on balancing the prisoner population to ensure greater safety at each facility. As a result of these efforts, the facilities are consistently operating under the established capacity levels.

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MR. BALLARD explained that during the administrative review process for any inmate death, the CMO conducts a comprehensive review of the electronic medical record to determine whether any facets of care or lack thereof could have contributed to the outcome.

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MR. RUTHFORD acknowledged that DOC is one of the largest behavioral health providers in the state, which the system was not designed for. He described the new electronic health record that was purchased in 2022, which allowed the department to access industry standards and add evidence-based tools to screen for and triage individuals with addiction and mental health issues. In addition, the department has identified high risk areas, such as booking, intake, and segregation, and established mandatory posts and additional rounds conducted by healthcare staff. The department's employees are one of its biggest assets, and as such, it has invested more in training to identify folks who are detoxing or struggling with mental health issues.

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MR. RUTHFORD informed the committee that he could not speak to the specifics of any particular case. In response to a series of committee questions, said the vast majority of inmates who are treated for mental illness are not violent and there is a process for housing them appropriately based on need.

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MR. BALLARD, in response to the chair's assertion that Mr. Farmer's death should have been ruled a death in custody as he sustained a [life-ending] traumatic brain injury while in his cell, said once the inmate is released from custody, he no longer has the legal allowance to investigate the death due to Health Insurance Portability and Accountability Act (HIPAA) law.

MR. NIGHSWONGER, in response to a question from the chair about who determines whether the death should be investigated as a crime, said the cause of death is outside the department's scope.

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MR. NIGHSWONGER, in response to a series of questions from Representative Kopp, spoke to the initial booking process and staffing levels. He explained that mandatory minimums at each facility establish a staffing profile for safe operations. If a facility dips below that level, people are called in for overtime to ensure safe operating levels. He said overtime is often used to fill shortages and offered to follow up with numbers of DOC staff, which he described as getting increasingly better.

MR. RUTHEFORD, in response to a question about the need for a third-party response team to prisoner death, acknowledged that DOC has discussed different options and engaged with the National Commission on Correctional Health Care, which offers industry standards and oversight for accredited facilities. Ultimately, DOC believes that the administrative reviews and the partnership with AST is the best option for Alaska's system.

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MR. RUTHERFORD, in response to a series of questions from Representative Vance, estimated that approximately 80 percent of the DOC population struggles with addiction related issues and spoke to the challenges of recruiting mental health service providers. He discussed the interface between the Alaska Psychiatric Institute (API) and DOC, which includes a jail-based restoration pilot program and weekly meetings between the two agencies regarding the competency evaluation and restoration process. He added that housing is largely determined by bed availability and the severity of the crime.

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MR. RUTHEFORD, in response to a series of questions from Representative Mina, explained that DOC tries to avoid segregating individuals on suicide precautions. If external factors of the case were identified as a concern, they would be reported on in the administrative review process. He said the administrative reviews have resulted in policy changes, staffing changes, and other measurable items and mitigation factors.

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MR. RUTHEFORD, in response to a series of questions from Chair Gray about the recording of inmate deaths within versus outside of custody, stressed the role that HIPPA and patient privacy plays.

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MR. BALLARD explained that if procedural issues were identified, medical operating procedures could be updated to ensure that staff are providing consistent care systemwide. He added that he had never witnessed individual neglect, but if it had occurred, a discussion on appropriate care would be had with leadership and clinical providers. He assured the committee that medical operating procedures give a foundation for junior providers to consistently practice in an evidence-based manner across all DOC facilities.

MR. RUTHEFORD said neglect could result in a wide array of actions ranging from additional training to termination.

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LIEUTENANT RONALD HAYES, Deputy Commander, Alaska Bureau of Investigations (ABI), Alaska State Trooper (AST), Department of Public Safety (DPS), Anchorage, Alaska, gave a PowerPoint presentation, titled "Investigations into Inmate Deaths," beginning on slide 2, "Notification & Scene Security," which read as follows [original punctuation provided]:

When an inmate death occurs, DOC staff notify the Alaska State Troopers.

For unanticipated deaths, DOC staff secure the area where the death occurred until Troopers and/or State Medical Examiner Staff arrive.

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LIEUTENANT HAYES continued to slide 3, "State Troopers Death Investigation," which read as follows [original punctuation provided]:

Troopers arrive and begin a death investigation—regardless of whether the death appears natural, accidental, or suspicious.

AST treats all unanticipated deaths as suspicious until proven otherwise.

AST will investigate the death in a similar manner that we investigate all unanticipated deaths that occur across Alaska.

LIEUTENANT HAYES described the investigative steps and the challenges faced during investigation.

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LIEUTENANT HAYES moved to slide 4, "Autopsy & Medical Examiner," which read as follows [original punctuation provided]:

The body is typically transferred to the State Medical Examiner's Office in Anchorage. An autopsy is conducted by the Medical Examiner to determine the cause and manner of death.

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LIEUTENANT HAYES, in response to a series of questions from members, confirmed that AST investigates assaults and deaths that occur both in and out of custody. He said AST has not experienced delayed reporting from correctional staff, adding that DOC is responsive in securing the scene, separating witnesses, and preserving evidence. He said AST did not play a role in DOC's Internal Affairs (IA) unit when it existed. He confirmed that in custody deaths must be reported.

[2:38:13 PM](#)

ALYCIA WELCH, Associate Director, Prison and Jail Innovation Lab, University of Texas (UT), gave a PowerPoint presentation, titled "The Landscape of Prison Oversight in the U.S." [hard copy included in the committee packet], beginning with the agenda on slide 2. She continued to slide 3, "What is the Prison and Jail Innovation Lab (PJIL)," which read as follows [original punctuation provided]:

The Prison and Jail Innovation Lab (PJIL) is a national policy resource center at the LBJ School of

Affairs at the University of Texas at Austin that is transforming the landscape of correctional oversight and helping to ensure the safe and humane treatment of people in custody.

We serve as a bridge between academic research, practical experience, and policy.

Since launching in late 2021, PJIL has been a go-to resource for policy makers, the media, justice system practitioners, advocates, and corrections officials on three main issues:

- 1) Effective oversight of prisons and jails
- 2) Dehumanizing and dangerous conditions behind bars
- 3) Deaths in custody

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MS. WLECH continued to slide 4, "What is the National Resource Center for Correctional Oversight (NRCCO)?" Slide 4 read as follows [original punctuation provided]:

The National Resource Center on Correctional Oversight (NRCCO) is a signature project of PJIL. The NRCCO provides guidance and research on how to develop or strengthen correctional oversight mechanisms and it operates an online clearinghouse of resources at www.prisonoversight.org.

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MS. WELCH continued to slide 5, "What is Correctional Oversight?" Slide 5 read as follows [original punctuation provided]:

An independent, external mechanism designed to ensure the collection, dissemination, and use of unbiased, accurate, and first-hand information about correctional conditions of confinement and the treatment of incarcerated individuals, primarily through on-site access to the facilities.

MS. WELCH turned to slide 6, "Why is Correctional Oversight Important?" Slide 6 read as follows [original punctuation provided]:

Oversight bodies can help prevent harm by identifying problems at an early stage.

Oversight bodies provide objective information for policy makers, advocates, and the media.

The presence of an oversight body in a facility can change staff behavior.

Oversight bodies provide a trusted place where incarcerated people and loved ones can raise concerns.

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MS. WELCH turned to slide 7, which highlighted the following goals of correctional oversight: improve transparency and increase accountability.

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MS. WELCH continued to slide 8, "Internal Accountability v. External Oversight," which read as follows [original punctuation provided]:

Effective prison management demands both internal accountability measures and external scrutiny. States can and should ensure that both exist.

INTERNAL ACCOUNTABILITY Tools for agency administrators that allow them to self-identify and address operational problems at an early stage.

Examples:

- Internal Affairs
- Grievance System
- Internal Auditors

EXTERNAL OVERSIGHT Entities that exist outside the agency and are responsible for:

- Routinely monitoring and inspecting facilities;
- Investigating complaints;
- Reporting their findings and recommendations to the public.

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MS. WELCH advanced to slide 9, which outlined 9 essential functions of correctional oversight: monitoring/inspection,

investigation, data collection and analysis, reporting, legal, regulation, legislative, accreditation, and audit. She emphasized that there should be a variety of separate oversight mechanisms in place to serve each function.

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MS. WLECH continued to slide 10, "What are the Hallmark Features of Correctional Oversight," which listed the following: Independence, mandated inspections, unfettered and confidential access, adequate resources, duty to report, holistic approach, mandated agency cooperation. She added that oversight bodies should not be enforcers and instead, sanction authority should be reserved for regulatory bodies with standards.

[2:55:46 PM](#)

MS. WELCH proceeded to slide 11, "Models of Prison Oversight," which read as follows [original punctuation provided]:

Governmental Agency or Inspectorate
Ombuds Office
Inspector General
Legislative Committee with Inspection Responsibilities
Non-Governmental Organization with Right of Access
Citizens' Board/Visiting Committee

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MS. WELCH advanced to slides 12-13, which showed a map of states with prison oversight in the U.S and touched on the growing movement to establish prison oversight. She concluded on slides 14-15 by sharing further resources prison oversight and an overview of NRCCO's website.

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MS. WELCH, in response to a series of committee questions, said there's no overlapping data on deaths in custody in states with external oversight. Part of the challenge is the federal Death in Custody Reporting Act. With regard to the deaths at Riker's Island, she pointed out that Rikers Island is a jail, not a statewide prison system and therefore, does not fall under the external oversight. She offered to follow up with the lab's report on natural deaths in custody.

[3:08:22 PM](#)

MR. RUTHEFORD added that Alaska is not currently accredited with the National Commission on Correctional Health Care (NCCHC), but recently went through a review for pre-accreditation to identify areas of improvement.

[3:09:24 PM](#)

ADJOURNMENT

There being no further business before the committee, the House Judiciary Standing Committee meeting was adjourned at 3:09 p.m.