JAIL SUICIDE/MENTAL HEALTH UPDATE

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SPECIAL ISSUE: INMATE SUICIDE LITIGATION REDUX

*In previous issues of the **Jail Suicide/Mental Health Update**, we have periodically discussed the relationship of inmate suicide and liability. These topics have become deeply intertwined, with the suicide of an inmate rarely occurring without the immediate question being asked — "Am I liable?" To date, the question is difficult to answer as courts continue to approach liability with inconsistency, leaving public officials, jail administrators, and their personnel often faced with confusing and unpredictable rulings.*

*In revisiting this topic, we again turn James E. Robertson, a Distinguished Professor of Corrections at Minnesota State University. In an earlier issue of the **Update** (Volume 6, Number 3, Spring 1996), Professor Robertson offered an article that analyzed the federal courts' interpretation of "deliberate indifference" — the legal yardstick used to measure most liability for inmate suicides. We recently asked Professor Robertson to revisit the topic and the result is "The Impact of **Farmer V. Brennan** on Jailers' Personal Liability for Custodial Suicide: Ten Years On." This special issue also includes an article by Jeffrey L. Metzner, M.D. regarding HIPPA regulations and mortality reviews for inmate suicides, a discussion regarding Bureau of Indian Affairs-run jail, and our regular news from around the country section.*

THE IMPACT OF *FARMER V. BRENNAN* ON JAILERS' PERSONAL LIABILITIY FOR CUSTODIAL SUICIDE: TEN YEARS ON

by
JAMES E. ROBERTSON, J.D.

> "A punishment is simply no less cruel or unusual because its harm is unintended." *Farmer v. Brennan*, 511 U.S. 825, 855 (1994) (Blackmun, J., concurring).

Suicide constitutes the leading cause of death in jail[1] and ranks third in prison.[2] Examples abound in every issue of the *Jail Suicide/Mental Health Update*. Take the case of Rodney Freeman Wilson.[3] His threat of suicide led jailers to place him on "suicide precautions," which directed that they observe him every 15 minutes. He hanged himself by smuggling in a towel after showering. His suicide went unobserved for 4 hours before staff resumed their watch. Wilson's death, like many before and after him, sadly occurred on the tenth anniversary of the Supreme Court's ruling in *Farmer v. Brennan*.[4] This decision mandated a subjective form of deliberate indifference, in which liability for a constitutional tort arises when "the official [actually] knows of and disregards and excessive risk to inmate health and safety."[5] Lower federal courts have since made *Farmer* the signal case in jail suicide litigation brought under 42 U.S.C. §1983. With the benefit of ten years of subsequent case law in the lower federal courts, this article examines the impact of *Farmer* on the personal liability of jailers for custodial suicide.

I. A Primer on *Farmer v. Brennan*

The facts of *Farmer* tell of an inmate-on-inmate assault that was just waiting to happen. Corrections staff had placed a transsexual inmate "project[ing] feminine characteristics" in the general population of a prison housing some of the most violent federal prisoners.[6] Bloodied and sexually violated by fellow inmates, he brought suit in federal district court and argued that prison officials had failed to safeguard him. He lost. Before a court of appeals he lost again. The Supreme Court sided with him — to a point.

The *Farmer* Court initially reaffirmed its earlier holdings in *Wilson v. Seiter*[7] and *Helling v. McKinney*[8] that the Eighth Amendment prohibition of cruel and unusual punishment forbids "'deliberate indifference' to a substantial risk of serious harm to an inmate."[9] Writing for the Court, Justice Souter then broke new ground by defining deliberate indifference as having *actual knowledge* of an objectively substantial risk of serious harm; and failing to take reasonable

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steps to abate that risk. Moreover, the *Farmer* Court operationalized the "actual knowledge" requirement as follows:

- To incur liability, "the official must *both* be aware of the facts from which the inference could be drawn that a substantial risk of serious harm exists, *and* he must also draw the inference."[10]

- When awareness can be inferred from circumstantial evidence, especially when the risk is "obvious," the trier of fact can conclude that the official "must have known" of the danger.[11]

- While ignorance of obvious risks will remain a defense, "[the] official would not escape liability if evidence showed he merely refused to verify underlying facts that he strongly suspected to be true, or declined to confirm inferences of risk that he strongly suspected to exist."[12]

Farmer constituted the doomsday decision for conditions of confinement litigation, according to *Harvard Law Review* staff. They decried that "[i]n announcing a subjective standard for deliberate indifference, the Court…created a virtually insurmountable barrier for inmates who challenge the conditions of their confinement."[13] How so? By making officers' actual knowledge of a high risk of injury a prerequisite for liability, the *Farmer* Court encouraged two defenses: the ostrich defense, in which defendants were ignorant of the facts demonstrating a high level of risk; and the ignorance defense, in which defendants knew the pertinent facts but failed to draw the requisite inference of a strong likelihood of suicide.

By contrast, I once viewed *Farmer* somewhat favorably. "[It is important to recognize," I explained to *Update* readers several years ago, "that *Farmer* abridged the difficult task of providing actual knowledge…[by showing] that correctional officers *must have known* of a risk that is *obvious*."[14] Indeed, the Court handed inmate Farmer a victory of sorts by ruling that his failure to inform prison staff of the dangers facing him did not preclude a finding of actual knowledge. Surely the perilous status of a transsexual prisoner would have been obvious even to a rookie officer.

II. The Origins of *Farmer's* Deliberate Indifference Test

Lower federal courts had employed variations of the deliberate indifference test long before *Farmer v. Brennan*. Its application to jail suicides seemed compelled by reasoning by analogy, the common law method of deciding cases. In Justice Marshall's majority opinion in *Estelle v. Gamble*,[15] analogy beckoned. The Court in *Estelle* held that deliberate indifference to a serious inmate medical need inflicted cruel and unusual punishment. Writing for the Court, Justice Marshall found guidance in the common law proposition that "it is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of liberty, care for himself."[16]

To lower federal courts, the suicide of an inmate also evidenced a serious medical need. As one early ruling concluded, "A psychological or psychiatric condition can be just as serious as any physical pathology or injury, especially when it results in suicidal tendencies."[17] But *Estelle* provided little guidance in the application of the deliberate indifference test. On this count, reasoning by analogy led to a dead end. Lower federal courts split into two camps over the content of the test. Some read it as an objective test — what defendants ought to have known.[18] Far more courts read it as a subjective test — what defendants in fact know.[19]

In *Wilson v. Seiter*,[20] the Supreme Court all but embraced the subjective test in ruling that that culpability "must be attributed to the inflicting officer before… [a deprivation of a basic human need] can qualify [as an Eighth Amendment violation]."[21] A bare majority of justices believed that the government's intent to do injury distinguished the punishment banned by the Constitution from other types of pain. On the other hand, four justices disagreed. They included Justice Marshall, whose majority opinion in *Estelle v. Gamble* inaugurated the deliberate indifference test. In a concurring opinion, the four asserted that culpability simply did not matter for the following reasons: first, the Court's own case law rested violations of the Eight Amendment solely on the severity of punishment; second, inquiry into prison officials' intent "simply is not very meaningful" because "inhumane prison conditions often are the result of cumulative actions and inactions by numerous officials inside and outside a prison."[22]

Three years later, *Farmer v. Brennan* explicitly ruled that deliberate indifference entails actual knowledge of a high risk of harm. The changing composition of the Court left but two justices to reiterate that the actual knowledge requirement lacked a sound basis in the Eighth Amendment jurisprudence.[23]

III. Suiciding Inmates and the Deliberate Indifference Test, 1994-2004

The Supreme Court adheres to the "rule model of precedent," whereby the Court decides the case before it and announces broad rules binding on inferior courts.[24] In apply the rules comprising the deliberate indifference test to jail suicide litigation, the inferior federal courts have created fact-specific case law. The reader should be cautioned that fact-specific case law invites exceptions to general observations.

Proving deliberate indifference had been a significant hurdle before *Farmer*; it remains so after *Farmer*. The Sixth Circuit Court of Appeals did not exaggerate when it described the plaintiff's burden as "onerous."[25] Establishing the personal liability of jailers rests on affirmatively answering two challenging questions:

- First, did the defendant jailers have actual knowledge of an objective, excessive risk of suicide?

- Second, assuming they possessed actual knowledge, did the defendants respond in a reasonable manner?

A) Did the Jailer have Actual Knowledge of an Objectively Excessive Risk?

Many lower federal court opinions have not drawn a sharp distinction between actual knowledge of an excessive risk and whether the suiciding inmate objectively presented an excessive

risk. The two issues overlap somewhat. This article will examine them separately because the suiciding inmate must have objectively presented an excessive risk regardless of the defendants' perception. Once it is determined that an objective, excessive risk existed, the inquiry shifts to whether the defendant jailers in fact knew of and appreciated this degree of danger.

1. Is the Degree of Risk Objectively "Substantial" or "Excessive?"

Justice Souter's majority opinion in Farmer stated that "[f]or a claim…based on a failure to prevent harm, the inmate must show that he is incarcerated under conditions positing a substantial risk of serious harm."[26] Later, he spoke of this degree of risk as an "excessive risk to inmate safety."[27] Justice Souter provided no meaningful elaboration.

How do lower federal courts determine whether the risk of suicide reached the "substantial" or "excessive" threshold? The facts and holding of *Bowens v. City of Atmore*[28] are instructive on this point of law. Ms. Bowens never had a chance in life: a biographical sketch would recount her being raped as a child, hobbled by a border-line I.Q, expelled after the seventh grade, addicted to cocaine, and prone to hearing voices telling her to kill herself. Bowens' perilous mental state soon became apparent upon her jailing for shoplifting. She tore up her cell mattress, foamed at the mouth, made animal-like noises, and declared that she would take her own life if she remained jailed. On the day of her suicide, staff monitored her throughout the day. She displayed no evident signs of depression.

Her family sued following her suicide. As to the liability of the on-duty jailer, the district court's analysis mirrored the extant case law of the post-*Farmer* era. Recall that before *Farmer*, some courts, including this district court, had held jailers to a standard of what they ought to have known. But as the *Bowens* court observed, the objective concept of deliberate indifference was "no longer good law."[29] There were new ground rules: "While the defendant's denial of subjective awareness is not depositive, the plaintiff must provide sufficient circumstantial evidence, including the obviousness of the facts and of the resulting inference of risk, to support a finding of subjective awareness and appreciation."[30]

The outcome in the *Bowens* case, however, turned on whether the inmate's mental condition presented an objectively excessive risk of suicide. To gauge an "excessive risk," this court, like several other courts, adopted the pre-*Farmer* tenet that "[i]n the absence of a previous threat of or an earlier attempt at suicide, we know of no federal court in the nation or any other court within this circuit that has concluded that official conduct in failing to prevent a suicide constitutes deliberate indifference."[31]

Some fifty-two days before her death, inmate Bowens had attempted suicide — and the jailers may have known about it. Citing exclusively pre-*Farmer* case law, the court nonetheless held that at the time of her death she no longer presented an excessive risk of suicide because of the lapse of time since her attempted suicide. Circuit case law, like pre-*Farmer* case law, dictated that remote suicide attempts do not create a strong likelihood of present danger. Consequently, it did not matter whether the defendant should have appreciated the countdown to her death and taken additional preventive measures.

2. Is the Risk Known or Obvious?

a) The Known Risk

Typically, a known risk arises from jailers' direct exposure to a "somewhat recent" suicide threat or attempt.[32] See *Greffey v. State of AL. Dept of Corrections*, 996 F. Supp. 1368 (N.D. Ala. 1998).

Following pre-*Farmer* case law, courts continue to rule that this kind of knowledge lapses with the passage of a few weeks.[33] Moreover, the threat must be discernibly genuine.[34]

Actual knowledge can also be acquired by having a third-party inform the defendant of a threatened or attempted suicide. This third party need not render a professional opinion; indeed, often it is a parent or law enforcement official.[35] However, at least one circuit court has asserted that a single third-party phone call in the absence of other collaborative information "most likely" will not provide the requisite knowledge.[36]

Jailers have no constitutional duty to seek out this knowledge. Consequently, case law still does not mandate screening for suicidal tendencies, and if it is undertaken, it does not have to done correctly.[37] Nor must jailers secure medical records from a hospital that treated an inmate upon a prior suicide attempt.[38] Similarly, jailers have no constitutional duty to inquire about suicidal tendencies when they receive an inmate from transporting officers or replace fellow officers in a change of shifts.[39] However, an officer transporting a suicidal inmate to another facility has an ongoing duty to warn the receiving institution.[40]

On the other hand, jailers cannot consciously avoid acquiring knowledge of a high risk of imminent suicide. As the court in *Terry v. Rice*[41] wrote: "Being an ostrich involves a level of knowledge sufficient for conviction of crimes requiring specific intent. Because it is sufficient for criminal liability, it is sufficient for liability under the eighth amendment's subjective standard."[42]

b) The Obvious ("Must Have Known") Risk

Given the difficulties of showing actual knowledge of a high risk of harm to inmates, plaintiffs allege the obviousness of the risk of suicide as a matter of course. Courts carefully scrutinize "must have known" claims, and they do not readily conclude that plaintiffs have averred sufficient facts to survive summary judgment. Even when the inmate is housed or otherwise classified as a suicide risk, courts may balk unless this housing is reserved exclusively for prisoners presenting an imminent, high risk of suicide.[43]

Only the Seventh Circuit has articulated reasons for the pronounced reluctance to side with "must have known" assertions. One rationale posits that courts should not be overzealous in drawing this inference because jail staff must weigh inmates' right to safety against their right to be free of unnecessary restraints imposed for psychiatric reasons.[44] The other rationale acknowledges that imprisonment greatly taxes the mental health

of inmates, leading to "signs of depression" or "strange behavior" that are not necessarily indicative of a high risk of suicide.[45]

Suggestive conduct that stops short of a suicide threat or attempt almost always fails to create an "obvious" significant risk of suicide. Examples include intoxication, sadness, unhappiness, abnormal behavior, anger, freaky behavior, strangling gestures, depression, self-inflicted cuts, scars, crying, whimpering, violence, bizarre behavior, psychiatric disturbance, glum demeanor, and drawings depicting sadness.[46] In rejecting these factors as less than obvious predictors of suicide, courts – once again – often cite pre-*Farmer* case law.

Only when the totality of events weigh heavily in the plaintiff's favor does a "must have known" claim have a reasonable likelihood of succeeding. These cases usually address what one court described as "odd behavior coupled with actual information that the individual is at risk of suicide… ."[47] Take the ruling in *Sanville v. McCaughtry*.[48] The court found sufficient proffered evidence to establish that jailers "must have known" about a strong likelihood of suicide. Note the court's lengthy rendition of suggestive, circumstantial evidence:

> [The plaintiff] asserts that the guards already knew: 1) that Matt [the deceased inmate and son of the plaintiff] had written a last will and testament contemplating his imminent death and telling his mother how to carry on his affairs after he died; 2) that Matt told certain guards that he planned to commit suicide; 3) that he had attempted suicide in the past; 4) that he had a long history of mental illness; 5) that he was not eating and was dangerously thin; and 6) that his mother had called the prison to alert them that he was paranoid, suicidal, and in trouble.[49]

Even in rather compelling "must have known" cases, plaintiffs sometimes fail to convince skeptical courts. For example, in *Strickler v. McCord*,[50] the plaintiff sued after he attempted custodial suicide. His incarceration stemmed from a drunken driving accident. Although his vehicle contained a suicide note, he denied a nexus between the note and his automobile accident. When completing the medical screening form at the defendant's jail, he indicated he was not at risk of suicide. However, over the course of the next two months, he engaged in a host of behaviors he would later characterize as obvious warning signs of a forthcoming suicide attempt. These included his carving his ex-wife's initials on his body with a contraband razor blade; his drawing a picture with "a gravestone with the inscription and the words, 'Dead Man Walking;'" his letters to certain family members that "could be interpreted as expressing an intent to commit suicide;" his placement in a holding cell that a jail manual stipulates as appropriate housing for suicidal inmates; and this brother-in-law telling jailers that the plaintiff "might be suicidal" because he stated that he was "tired of it all" and "he really didn't care what happened from this point."[51] The court found this proffered evidence insufficient to establish that the individual jailers' "must have known" of his continuing high risk of suicide. For instance, the circuit panel rejected self-mutilation as an obvious sign; characterized his depiction of his gravestone as an "express[ion] of sadness, frustration,[and] anger;" and observed that his mental health evaluation revealed "thoughts and threats of suicide but no clear expression of suicidal intent."[52] At the close of its written opinion, the court articulated its bottom line: the plaintiff's risk of suicide "was not much greater that the general jail population, where …inmates are nine times as likely to commit suicide than people in the general public."[53]

WE'RE LOOKING FOR A FEW GOOD PROGRAMS

Future issues of the ***Jail Suicide/Mental Health Update*** will be devoted to exemplary suicide prevention programs operating within correctional facilities throughout the country. Does your facility's suicide prevention policy contain, and do your practices reflect, the following critical elements?

- Intake screening to detect both current and prior suicidal behavior, as well as further and periodic assessment of suicide risk by mental health staff;
- Suicide prevention training for correctional, medical, and mental health staff;
- Levels of communication between outside agencies, among facility staff, and with the suicidal inmate;
- Suicide-resistant, protrusion-free housing of suicidal inmates;
- Levels of supervision for suicidal inmates;
- Timely emergency intervention by correctional and medical personnel following a suicide attempt;
- Provision of critical incident stress debriefing to affected staff and inmates, as well as completion of a multidisciplinary mortality review following an inmate suicide and/or serious suicide attempt; and
- A low rate of inmate suicides for an extended period of time.

If you believe your correctional facility operates an exemplary suicide prevention program, and would like it to be considered as a possible case study in an up-coming issue of the ***Update***, please contact:

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B) Having the Requisite Knowledge, Did the Jailer Respond in a Reasonable Manner?

In *Coleman v. Parkman*,[54] the Court of Appeals for the Eighth Circuit wrote, "Once an official knows of a risk, the Eighth Amendment requires the official take reasonable measures to abate the risk."[55] In support of this proposition, the court cited only circuit case law and thus made no mention of *Estelle v. Gamble*, *Wilson v. Seiter*, or *Farmer v. Brennan*. This omission is not surprising given the Supreme Court's failure to elaborate on the reasonableness standard it endorsed.[56] Left to their own devices, lower federal courts have largely adhered to pre-*Farmer* case law in stating the constitutional minima due suicidal inmates.

Surveillance remains a keystone of reasonableness. The manner and interval of surveillance can fall far below recommended standards and remain "reasonable" as defined by case law. Moreover, surveillance consistent with constitutional minima will not prevent a resourceful inmate – including one known to present a high risk of suicide - from taking his own life. For instance, monitoring on a 15-minute basis, which is far longer than the time needed to kill oneself, can insulate a jailer from potential liability even when in violation of certain state standards.[57] Lower federal courts have not mandated continuous monitoring[58] nor directed personal observation when video monitoring scans most of the cell.[59] Even reliance on defective video equipment monitored by an untrained clerk meets the constitutionally required level of care.[60]

Similarly, the case law on denying inmates the means of self-injury allows for less than thorough measures. *Thornhill v. Breazeale*[61] illustrates how jailers' omissions can aid in a suicide yet remain judgment proof in constitutional tort actions. The deceased's two prior suicide attempts led to his placement on suicide watch in the "mental holding cell," which called for personal monitoring every 15 minutes and the removal of shoes, belts, and the like. Later the sheriff, who ordered the suicide watch status for this man, moved him to another cell, which came outfitted with a non-break away shower rod. Subsequently, a deputy, who also knew of this inmate's strong likelihood of suicide, failed to remove his shoes upon the completion of the detainee's exercise period. He then used his shoelaces to hang himself from the non-break away shower rod. In district court, the jailers won a summary judgment. Because the sheriff's placement of the deceased in a cell ready made for hanging had occurred independent of his deputy's failure to remove the man's shoes, neither the sheriff nor deputy's acts constituted deliberate indifference.

IV. Conclusion

Writing in the ***Update*** two years before the *Farmer* ruling, Fred Cohen aptly described jail suicide case law as placing a "premium…[on jailers'] ignorance, a premium which is anti-therapeutic and life-threatening."[62] The premium largely arose from the subjective concept of deliberate indifference.

The Supreme Court in *Farmer v. Brennan* included an addendum to this test that permitted a finding of actual knowledge when officials "must have known" of the danger.[63] However, jail suicide litigation demonstrates that even good "must have known" arguments sometimes fail. Consequently, ten years of post-*Farmer* case law has effected only a small reduction of the "premium" on ignorance.

By the Supreme Court's own admission, its deliberate indifference test requires a degree of culpability that "track[s]" criminal recklessness.[64] In setting the constitutional bar at this low level, the Court in *Farmer* diminished the moral standing of the Eighth Amendment's prohibition of cruel and unusual punishment.

Reference Notes

[1]See J. Richard Goss et al. (2002), "Characteristics of Suicide Attempts in a Large Urban Jail System with an Established Suicide Prevention Program," *Psychiatric Services*, 53: 574-579.

[2]See Lance Couturier & Frederick R. Maue (2000), "Suicide Prevention Initiatives in a Large Statewide Department of Corrections: A Full-Court Press to Save Lives," *Jail Suicide/Mental Health Update*, 9 (4): 1-8.

[3]See Lindsay M. Hayes (2004), "News From Around the Country," *Jail Suicide/Mental Health Update*, 12 (4): 14-15.

[4]511 U.S. 825 (1994).

[5]*Id*. at 837.

[6]*Id*. at 825.

[7]501 U.S. 294 (1991).

[8]509 U.S. 25 (1993).

[9]*Id*. at 838.

[10]*Id*. (emphasis added).

[11]*Id*. at 827.

[12]*Id*. at 843.

[13]See "The Supreme Court, 1993 Term, Leading Cases," 108 *Harvard Law Review*, 231, 231 (1994) (emphasis added).

[14]See James E. Robertson (1996), "Jailers' Liability for Custodial Suicide After *Farmer v. Brennan*," *Jail Suicide/Mental Health Update*, 6 (3): 1-5.

[15]429 U.S. 97 (1976).

[16]*Id*. at 103-04.

[17]Partridge v. Two Unknown Police Officers of Houston, 791 F.2d 1182, 1187 (5th Cir. 1986).

[18]See, e.g., *Colburn v. Upper Darby Township*, 946 F.2d. 1017, 1024 (3d Cir. 1991); *Popham v. City of Talladega*, 908 F.2d 1561, 1563 (11th Cir. 1990).

[19]See, e.g., *Estate of Hocker v. Walsh*, 22 F.3d 995, 1000 (10th Cir. 1994); *Bowen v. City of Manchester*, 966 F.2d 13, 17 (1st Cir. 1992).

[20]501 U.S. 294 (1991).

[21]*Id*. at 300.

[22]*Id*. at 310 (White, J., concurring).

[23]See *Farmer v. Brennan*, 511 U.S. 825 (1994) (Stevens, J., concurring) (Blackmun, J., concurring).

[24]See Larry Alexander (1989), "Constrained by Precedent," 63 *Southern California Law Review*, 1, 17.

[25]*Comstock v. McCrary*, 273 F.3d 693, 703 (6th Cir. 2001), *cert. denied*, 537 U.S. 817 (2002).

[26]*Farmer*, 511 U.S. at 834.

[27]*Id*. at 837.

[28]171 F. Supp.2d 1244 (S.D.Ala. Mar 27, 2001), *aff'd*, 275 F.3d 57 (11th Cir. 2001).

[29]*Bowens*, 171 F. Supp.2d at 1253.

[30]*Id*.

[31]*Id*. at 1254 (quoting *Edwards v. Gilbert*, 867 F.2d 1271, 1275 (11th Cir. 1989).

[32]See *Greffey v. State of AL. Dept of Corrections*, 996 F. Supp. 1368 (N.D. Ala. 1998).
[33]See, e.g., *Ellis v. Washington County*, 80 F. Supp.2d 791, 796, 801-02 (E.D. Tenn. 1998), *aff'd*, 198 F.3d 225 (6th Cir. 1999), *cert. denied*, 529 U.S. 1087 (2000).
[34]See, e.g., Domino v. Texas Department of Criminal Justice, 239 F.3d 752 (5th Cir. 2001).
[35]See *Cavalieri v. Shepard*, 321 F.3d 616 (7th Cir.), *cert. denied*, 124 S.Ct. 531 (2003).
[36]See *Gregoire v. Class*, 236 F.3d 413, 418 (8th Cir. 2000).
[37]See *House v. City of Macomb*, 303 F. Supp. 2d 850, 854 (E.D. Mich. 2004).
[38]*Hott v. Hennepin County*, 260 F.3d 901 (8th Cir. 2001).
[39]*Wilson v. Genesee County*, 2002 WL 745975 (E.D. Mich. 2002), rev'd in part, sub nom. *Wilson v. Roberts*, 73 Fed.Appx. 103, 2003 WL 21698899 (6th Cir. July 17, 2003).
[40]See *Cavalieri*, 321 F.3d at 623.
[41]2003 WL 19221818 (S.D. Ind. April 18, 2003).
[42]*Id*. at *15 (quoting *McGill v. Duckworth*, 944 F.2d 344, 351 (7th Cir. 1991), *cert. denied*, 503 U.S. 907 (1992)).
[43]See, e.g., *Collignon v. Milwaukee County*, 163 F.3d 982, 990 (7th Cir. 1998); *Estate of Cole v. Fromm*, 94 F.3d 254, 261 (7th Cir. 1996), *cert. denied*, 519 U.S. 1109 (1997).
[44]See *Estate of Cole*, 94 F.3d at 261.
[45]See *Matos v. O'Sullivan*, 335 F.3d 553, 558 (7th Cir. 2003).
[46]See, e.g., *Hott v. Hennepin County*, 260 F.3d 901, 905-06 (8th Cir. 2001); *Novack v. County of Wood*, 226 F.3d 525, 529 (7th Cir. 2000); *Brewer v. City of Daphne*, 111 F. Supp.2d 1299, 1317 (S.D. Ala. 1999).
[47]*Terry v. Rice*, 2003 WL 19221818, at *13 (S.D. Ind. April 18, 2003) (emphasis added).
[48]266 F.3d 724 (7th Cir. 2001).
[49]*Id*. at 737.
[50]306 F. Supp. 2d 818 (N.D. Ind. 2004).
[51]*Id*. at 820-23.
[52]*Id*. at 827.
[53]*Id*.
[54]349 F.3d 534 (8th Cir. 2003).
[55]*Id*. at 538.
[56]*Farmer v. Brennan*, 511 U.S. 25, 844 (1994).
[57]See, e.g., *Davis v. Fentress County, Tenn.*, 6 Fed. Appx. 243 (6th Cir. Tenn. 2001).
[58]See, e.g., *Hofer v. City of Auburn*, 155F. Supp. 2d 1308 (M.D. Ala. 2001).
[59]See, e.g., *Ziegler v. State of Michigan*, 90 Fed. Appx. 808 (6th Cir. 2004); see also, e.g., *Jacobs v. West Feliciana Sheriff's Dept*, 228 F.3d 399 (5th Cir. 2000).
[60]See, e.g., *Serafin v. City of Johnstown*, 53 Fed. Appx. 211 (3d Cir. 2002).
[61]88 F. Supp. 2d 647 (S.D. Miss. 2000).
[62]See Fred Cohen (1992), "Liability for Custodial Suicide: The Information Base Requirements," *Jail Suicide Update*, 4 (2): 1-11.
[63]*Farmer v. Brennan*, 511 U.S. 825, 827 (1994).
[64]*Id*. at 837.

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Inmate Suicide Case Law in the Federal Courts (2000 to the Present)

Offered below is a comprehensive listing of all inmate suicide case law from the federal courts, as published in either West's Federal Supplement or Federal Reporter from 2000 to the present. (Cited cases between 1995 and 2000 can be found in the ***Jail Suicide/Mental Health Update****, Volume11, Number 1, Spring 2002, pages 6-8.)*

2000

Anderson v. Simon, 217 F.3d 472, 7th Cir. 2000
(Prosecutor's decision to hold inmate overnight in police lockup in order to gather more evidence was sufficient use of prosecutorial discretion justifying immunity; suit against city and individual officers settled prior to trial based, in part, upon notice of decedent's suicide threat to officers)

Cills v. Kaftan, 105 F.Supp.2d 391, D. N.J. 2000
(Line jail personnel who took inmate off suicide watch were not liable; fact issues as to adequacy of policy governing suicide watch precluded summary judgment for remaining defendants)

Estate of Novack ex rel. Turbin v. County of Wood, 226 F.3d 525, 7th Cir. 2000
(While jail personnel perhaps could have done more to become aware of the danger that decedent posed to himself based on the strange behavior that he was exhibiting, no indication that jail policies caused personnel to be deliberately indifferent in the face of a patently obvious suicide risk)

Frake v. City of Chicago, 210 F.3d 779, 7th Cir. 2000
(Despite a history of prior suicides in the city's lockup facilities, the defendant was not deliberately indifferent because it had an adequate suicide prevention policy and was not aware that inmate was a suicide risk)

Gregoire v. Class, 236 F.3d 413, 8th Cir. 2000
(Case manager was not deliberately indifferent to inmate's risk of suicide and, therefore, entitled to qualified immunity)

Jacobs v. West Feliciana Sheriff's Dept, 228 F.3d 388, 5th Cir. 2000
(Sheriff and senior deputy, who knew of prior suicide under similar circumstances, could have been found to have acted with deliberate indifference to arrestee's known suicidal tendencies, but newly hired deputy, who only followed orders which were not facially outrageous, was entitled to qualified immunity)

Stewart v. Robinson, 115 F. Supp. 2d 188, D. N.H., 2000
(Summary judgment granted to all remaining defendants because no proof offered that they exhibited deliberate indifference to inmate)

Thornhill v. Breazeale, 88 F. Supp. 2d 647, S.D. Miss. 2000
(Plaintiffs' claims viable against county because there was a genuine issue of material fact as to whether jail policies and conditions were reasonably related to a legitimate governmental interest; summary judgment granted to sheriff and deputy in their individual capacities)

Yellow Horse v. Pennington County, 225 F.3d 923, 8th Cir. 2000
(Correctional officer who removed inmate from suicide watch, as well as officer on duty at time of suicide, were entitled to qualified immunity; suicide prevention policy did not reflect deliberate indifference)

Williams v. Kelso, 201 F.3d 1060, 8th Cir. 2000
(Officers' failure to check vital signs was a matter of negligence, at most, not deliberate indifference; no 8th Amendment requirement for jail staff to provide immediate medical attention to a disoriented, confused and belligerent detainee who had been arrested on an alcohol-related misdemeanor charge; there was no abuse of discretion in dismissing without prejudice the separate medical negligence and wrongful death claims against mental health care providers; jail supervisors entitled to qualified immunity on claim that they failed to segregate decedent upon booking)

Wilson v. City of Kalamazoo, 127 F.Supp. 2d 855, W.D. Mich. 2000
(Defendants not justified in completely striping inmates naked, even for a short period of time, simply because they refused to answer a question as to whether they were suicidal)

2001

Boncher v. Brown County, 272 F.3d 484, 7th Cir. 2001
(Evidence regarding inadequate training, intake screening, and number of suicides in jail insufficient to show that jail officials were deliberately indifferent to risk of inmate's suicide)

Bowens v. City of Atmore, 171 F.Supp. 2d 144, S.D. Al. 2001, *aff'd* 275 F.3d 57, 11th Cir. 2001
(Defendants granted summary judgment because inmate's history of suicidal behavior and suicide attempt in same jail several weeks prior to death does not reflect "strong likelihood" of suicide at the time of her death)

Brown v. Harris, 240 F. 3d 383, 4th Cir. 2001
(Evening assuming that jail supervisor was informed that inmate was suicidal, he did not act with deliberate indifference when he placed inmate on "medical watch" with video surveillance)

Comstock v. McCrary, 273 F.3d 693, 6th Cir. 2001
(Evidence was sufficient to establish that prison psychologist subjectively perceived, and that he was deliberately indifferent to risk, that inmate might commit suicide; inmate's constitutional right to continuing medical treatment, once he had been determined to be suicidal, was clearly established)

Domino v. Texas Department of Criminal Justice, 239 F.3d 752, 5th Cir. 2001
(Psychiatrist's incorrect diagnosis that inmate's suicide threat was not genuine, but was made to obtain secondary gain, did not amount to deliberate indifference, although it might exemplify medical malpractice)

Ellis v. Jamerson, 174 F. Supp. 2d 747, E.D. Tenn, 2001
(Statement by county sheriff to media that jailer was watching television monitor and observed inmate put sheet around his neck was not admissible under public records and reports exception to hearsay rule)

Hanchett v. Saline County Board of Commissioners, 194 F. Supp. 2d 1150, D. Kan. 2001
(Defendant's motion to dismiss granted because both Plaintiff's wrongful death and civil rights complaints were time-barred by statute of limitations; claims that statute of limitations should be extended because family was "dysfunctional for some months after the death of their son" and were unaware that defendants "had notice of the dangerous condition of the vents (from two recent prior suicides) and had a reasonable opportunity to correct this dangerous condition but failed to do so" was unsupported)

Hofer v. City of Auburn, 155 F. Supp. 2d 1308, M.D. Al. 2001
(Plaintiff could not establish that jail officials acted with deliberate indifference in failing to take preventative measures to avoid detainee's suicide attempt; evidence of prior suicide at city jail by hanging from protruding light fixture did not establish that officials were deliberately indifferent by failing to remove coat hook from jail cell)

Holland v. City of Atmore, 168 F. Supp. 2d 1303, M.D. Al. 2001
(Defendants granted summary judgment because inmate's recent suicide attempts several months prior to death did not reflect "strong likelihood" of suicide at the time of his death; jail officials' failure to prevent suicide did not violate sections 1985 and 1986)

Hott v. Hennepin County, 260 F.3d 901, 8th Cir. 2001
(Jail officer's alleged failure to conduct regular cell checks was negligent, but not deliberate indifference; jail was not negligent in failure to train and supervise staff in suicide prevention)

Jutzi-Johnson v. United States, 263 F.3d 753, 7th Cir. 2001
(Reversal of lower court bench trial verdict for plaintiff; no causal relation between jail staff's negligence and inmate's suicide because death not foreseeable)

Naumoff v. Old, 167 F. Supp. 2d 1250, D. KS. 2001
(Mother of decedent brought suit in her individual capacity, not as representative of her son's estate, and has no standing because she failed to make a claim for deprivation of familial association)

Sanville v. McCaughtry, 266 F.3d 724, 7th Cir. 2001
(Prison officers were aware of the substantial risk that inmate would commit suicide; viable claim that officers failed to take reasonable steps to prevent inmate's suicide; officers not entitled to qualified immunity on section 1983 individual liability claims; Prison physicians were not deliberately indifferent to the substantial risk that inmate would commit suicide)

Singletary v. Pennsylvania Department of Corrections, 266 F. 3d 186, 3rd Cir. 2001
(Summary judgment for prison superintendent affirmed because no evidence of deliberate indifference; motion to further amend complaint to include prison psychologist denied because it was time-barred by statute of limitations)

2002

Pelletier v. Magnusson, 201 F. Supp. 2d 148, D. Maine, 2002
(Summary judgment granted to four mental health staff because their questionable care of inmate did not rise to the level of deliberate indifference)

Rapier v. Kankakee County, 203 F. Supp. 2d 978, C. D. Ill, 2002
(County was not liable for inmate's suicide because it would be mere "speculation to determine that additional staff would have" checked on inmate more frequently, and the jail had a policy of checking on suicidal inmates every 15 minutes and an officer observed and spoke to inmate in his special needs cell approximately 15-20 minutes prior to the time he was found hanging in his cell)

2003

Cagle v. Sutherland, 334 F. 3d 980, 11th Cir. 2003
(Although inmate threatened suicide and left unobserved in cell for approximately one hour and 46 minutes, county not deliberately indifferent because jail staff removed his belt and shoelaces, and most of cell could be observed by closed circuit television monitoring; county's failure to hire additional staff, albeit a violation of previous consent decree, did not establish violation of constitutional rights)

Cavalieri v. Shepard, 321 F.3d 616, 7th Cir. 2003
(Police officer could be found deliberately indifferent if he failed to communicate arrestee's possible suicide risk to county jail staff)

Coleman v. Parkman, 349 F.3d 534, 8th Cir. 2003
(Placement of inmate on suicide watch in unsafe drunk tank with a bedsheet that was not readily observable to jail staff could exemplify deliberate indifference)

Crocker v. County of Macomb, 285 F. Supp. 2d 971, E.D. Mich. 2003
(Summary judgment granted to defendants because inmate did not show any indication of suicidal behavior)

Gray v. Tunica County, 279 F. Supp. 2d 789, N.D. Miss. 2003
(Plaintiffs failed to show that county's policies were so inadequate to have been the proximate cause of the inmate's suicide; placement of inmate in padded "lunacy" cell because of disruptive behavior was designed to protect him from harm)

Matos v. O'Sullivan, 335 F.3d 553, 7th Cir. 2003
(Plaintiff's failed to show that defendants had actual knowledge of inmate's current risk for suicide, that is, the inmate never expressed suicidal behavior nor did the treating mental health staff ever assess him as a current risk for suicide; inmate's history of depression and substance abuse, prior suicide attempt three years earlier, distress over father's recent death, and unhappiness over transfer to a lock-down unit were not remarkable enough to indicate a risk of suicide)

Office of Protection and Advocacy for Persons with Disabilities v. Armstrong, 266 F. Supp. 2d 303, D. Ct. 2003
(Based upon the federal Protection and Advocacy for Mentally Ill Individuals Act, the state prison system was required to comply with plaintiff request for all records pertaining to several inmates that committed suicide)

Olson v. Bloomberg, 339 F.3d 730, 8th Cir. 2003
(Although a correctional officer took some measures in response to inmate's suicide threat, deliberate indifference could be shown if officer subsequently left the cell area, refused to return, and caused an intentional delay in rescue efforts)

Reed v. City of Chicago, 263 F. Supp. 2d 1123, N.D. Ill. 2003
(Manufacturer of paper gown allegedly marketed for use by suicidal inmates could be held liable when it failed to tear away when detainee hanged himself)

Sisk v. Manzanares, 270 F. Supp. 2d 1265, D. Kan. 2003
(Court upholds jury verdict finding of negligence under state law and no deliberate indifference in failing to prevent an inmate's suicide; jury award of $10 million reduced to $252,000 because state statutory limit on wrongful death awards)

2004

Dipace v. Goord, 308 F. Supp. 2d 274, S.D.N.Y. 2004
(Defendants entitled to qualified immunity because case law existing in 1999, the time of the inmate's suicide, declared that the failure to conduct CPR did not constitute a constitutional violation; however, in light of more recent case law, "it would be reasonable to conclude today that prison officials have a duty to administer life-saving care even in the absence of a pulse or respiration where circumstances indicate the possibility of a very recent death and the individuals are available to give such care)

House v.County of Macomb, 303 F. Supp, 2d 850, E.D. Mich. 2004
(Summary judgment granted to defendants because argument that defendants who came into contact with inmate "should have known" that she was suicidal or otherwise facing an excessive risk to her health and safety was not enough to establish deliberate indifference)

Strickler v. McCord, 306 F. Supp. 2d 818, N.D.Ind. 2004
(Summary judgment granted to defendant because plaintiff did not show that his suicide attempt was foreseeable, or that jail staff had actual knowledge that he was at high risk for suicide)

Turney v. Waterbury, ___ F.3d ___, 8th Cir. 2004, WL 1594187
(Summary judgment affirmed for all defendants, except sheriff, because their conduct was negligent at best; sheriff's knowledge of inmate's suicide risk, which included not investigating an earlier suicide attempt, not permitting an officer to complete the inmate's intake form, placing the inmate in a cell alone with a bed sheet and exposed ceiling bars, and ordering the jail's lone officer not to enter the inmate's cell without backup were facts which a jury could find exhibit deliberate indifference)

Woodward v. Correctional Medical Services, 368 F.3d 917, 7th Cir. 2004
($1.75 million jury award was affirmed; defendant was aware of inmate's suicide risk, custom and practice was to tolerate and/or encourage its employees to not follow policies, and there was a "direct casual link" between the defendant's deviation from its established policies and inmate's suicide) ❑

HIPPA: DOES IT CAUSE BARRIERS TO CONDUCTING MORTALITY REVIEWS?

by
JEFFREY L. METZNER, M.D.

An April 6, 2004 article in *Florida Today* reported that a sheriff was having difficulty determining whether "a slip-up in medical care could have contributed to any of the five recent inmate suicides at a county jail" due to apparent problems caused by the

Health Insurance Portability and Accountability Act of 1996 or HIPAA.

According to the newspaper article, the county has a contract with a non-profit agency to provide mental health services at the jail. The report was vague concerning the perceived HIPAA obstacles, but it appeared to imply that the legal representatives of the deceased inmates needed to provide written authorization for the sheriff's department to have access to relevant health care records generated at the jail, which were obviously needed in order to assess individual and system issues concerning these suicides, all of which occurred within a four-month period of time. "Because of the HIPPA regulations, we just can't charge in there and gather up every medical record. We have to work with attorneys at each stage of it," the sheriff told *Florida Today*. "It is definitely slowing us down."

HIPAA, which is a complicated and often misunderstood federal law, was enacted by Congress in 1996. Title I of the Health Insurance Portability and Accountability Act of 1996 protects health insurance coverage for workers and their families when they change or lose their jobs. The Administrative Simplification provisions of HIPAA (Title II) established a process for developing federal rules regarding the transmission and safeguarding of electronically shared health information. The Administrative Simplification provisions include rules concerning electronic transactions and code sets, security, unique identifiers and privacy. The Privacy Rule (enforceable as of April 14, 2003) established standards for use, disclosure, and protection of all health information created by "covered entities." It appears that the sheriff was referring to the Privacy Rule as being an obstacle to the obviously needed mortality reviews.

This article will attempt to address issues pertinent to mortality reviews in correctional settings within the context of HIPAA. It is not intended to be a comprehensive review of HIPAA and assumes that ***Update*** readers are familiar with key HIPAA concepts involving covered transactions, covered entities, protected health information, notice, consent, authorization, mandatory and permissive provisions, exceptions and more stringent state laws. There is an abundance of useful information relevant to HIPAA on the web. An excellent starting point is the Centers for Medicare & Medicaid Services (CMS) web site at www.cms.hhs.gov/hipaa/hipaa2/default.asp.

Only "covered entities" are required to follow HIPAA guidelines. Not all correctional facilities (or healthcare providers) meet the criteria for a covered entity. A healthcare provider or healthcare facility (e.g., hospital, medical clinic within a jail or prison) is a covered entity if as a healthcare provider the individual clinician or healthcare organization directly or indirectly engages in at least one standard electronic transaction (i.e., a "covered transaction"). Such covered transactions include, but are not limited to, healthcare claim status, health claims or equivalent encounter information, healthcare payment and remittance advice, referral certification and authorization, enrollment and disenrollment in the health plan, health plan eligibility, including coverage and benefits information, health plan premium payments and coordination of benefits.

Not surprisingly, the Privacy Rule (45 CFR Parts 160 and 164) (August 14, 2002) provides definitions of electronic transmission and healthcare, which are mainly commonsense but have some distinct nuances. For example, while paper to paper faxes are not considered to be electronic transmission under HIPAA, a computer to paper fax of health information in connection with a covered transaction would qualify a provider as a covered entity. Other issues that need to be addressed in determining whether a health services provider meets the criteria for covered entity status includes topics related to the HIPAA definitions of health plans, healthcare clearinghouses and business associate relationships.

It is not surprising that correctional facilities seek legal advice in determining whether or not they meet the criteria of being a covered entity in the context of HIPAA. For the purposes of this article, it will be assumed that the previously referenced county jail in Florida is considered to be a covered entity because the non-profit mental health services provider, which has a contract with the county to provide the mental health services to the jail, is a covered entity.

The Office of Civil Rights (United States Department of Health and Human Services) has provided a summary of the HIPAA Privacy Rule [OCR Privacy Rule Summary (2003) at www.hhs.gov/ocr/privacysummary.pdf last accessed April 8, 2004] that states the following:

> A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, the Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.

The basic principle underlying the Privacy Rule is to define and limit circumstances in which an individual's protected health information (PHI) may be used or disclosed by covered entities. "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral, is considered to be protected health information. PHI may not be used or disclosed by a covered entity except as the Privacy Rule permits or requires or when the individual (or their personal representative), who is the subject of the PHI provides written authorization.

The Privacy Rule permits a covered entity to use or disclose PHI, without an individual's authorization, in a number of situations that includes "for its own treatment, payment, and health care operation activities" (TPO) [OCR Privacy Rule Summary (2003)]. The Privacy Rule subsequently defines treatment, payment, and health care operations. For purposes of the mortality review being discussed, the definition of health care operations is pertinent. Among the activities included in this definition include the following:

- quality assessment and improvement activities, including case management and care coordination, and
- competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation.

A key aspect of the Privacy Rule is the principle of "minimum necessary" use and disclosure. Reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request, is required of the covered entity. The covered entity is required to develop and implement policies and procedures related to the concept of "minimum necessary." There are also certain exceptions to the minimum necessary requirement, which are described in the Privacy Rule.

A covered entity must obtain the individual's written authorization for any use or disclosure of protected health information that is not for treatment, payment or healthcare operations or otherwise permitted or required by the Privacy Rule. The Privacy Rule provides clear structure for the nature of the written authorization that is required for such use or disclosure of PHI.

Now back to the dilemma that the Sheriff is describing. Assume that the non-profit mental health agency (Agency X) providing services to the jail has directly contracted with the Sheriff's Department in contrast to a different county authority. Agency X should not have any significant HIPAA related problems in accessing relevant healthcare records of the inmates who committed suicide, if the review is done as part of a quality assurance process, which would fall under the TPO exception. The minimum necessary principle would not prevent Agency X from having access to the complete healthcare records of these individuals due to the nature of the review required. In these circumstances, the Sheriff's Department would obviously have access to the findings of the mortality review because Agency X is essentially by contract part of the Sheriff's Department within the context of HIPAA.

Appropriate custody staff should have participated in the mortality reviews as part of the quality assurance process if the quality assurance process at the correctional facility had been properly established. Specifically, quality assurance/improvement processes within correctional facilities should include both healthcare and custody staffs working together related to the obvious need for good working relationships between them to facilitate various healthcare and custody operations. Under this contractual arrangement, any problems in the mortality reviews related to HIPAA would reflect a misunderstanding of the Privacy Rule and would be most likely related to a faulty quality assurance process.

Assume that Agency X is another county agency that does not administratively report to the Sheriff's office by contract, but does provide the mental health services to the jail via direct funding from the county commissioners in contrast to the Office of the Sheriff. Does HIPAA create barriers for the Sheriff's investigation of the suicides? The answer to this question will depend on structural (and ultimately quality) issues concerning the nature of the healthcare delivery system. The administrative structure of correctional mental health services is a complex issue due to the diversity of correctional settings and variety of organizational structures. Correctional health care systems' administrative structures range from the traditional decentralized model to a totally centralized system with variations between these models.

Although there are many different correctional healthcare services delivery models, some basic principles apply to all of them. Among these principles include the establishment of an adequate suicide prevention program. The National Commission on Correctional Healthcare (NCCHC) standards for jails and prisons (NCCHC, 1996, 1997) state: "written policy and defined procedures require, and actual practice demonstrates, that the prison [or jail] has a program for identifying and responding to suicidal inmates. The program components include: training, identification, monitoring, referral, evaluation, housing, communication, intervention, notification, reporting, review, and critical incident stress debriefing." Detailed discussions of the specific components are provided in a later NCCHC publication (2003).

The review component of the suicide prevention program should be done as part of the correctional healthcare systems quality improvement process, which has various acronyms including CQI, TQI, QI, etc. Quality assurance (QA) is one aspect of a quality improvement process. A comprehensive quality improvement (QI) program involves a multidisciplinary quality improvement committee of health care providers who meet regularly with correctional administrators to design QI monitoring activities and to review the results. In other words, the QI process should include both healthcare and custody staff. HIPAA would not provide any significant obstacles to mortality reviews in a correctional setting if the QI process is established in this fashion regardless of the organizational structure of the specific correctional healthcare system in question.

HIPAA could certainly provide obstacles to an effective mortality review process if the quality improvement process has not been properly designed and/or implemented. However, the remedy in such circumstances should not be amending HIPAA; rather it should involve establishment of an adequate quality improvement process, which is very compatible with current HIPAA regulations.

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Bureau of Indian Affairs — Run Jails Called A "National Disgrace"

The U.S. Department of the Interior's Bureau of Indian Affairs (BIA) is investigating the suicide of an inmate at the Yakama Tribal Detention Center near Toppenish, Washington amid growing concerns about Indian Country detention facilities throughout the country. The inmate, 40-year-old Ricky Owens Sampson, was left hanging for at least five hours — long enough for rigor mortis to set in — because the jail had just one officer on duty during the night of June 25, 2004. Family members believe that Mr. Sampson was left hanging in the cell for a much longer period of time, and tribal Police Chief Elliot Lewis believes they might file a lawsuit. "I'm concerned about how long he was left," Chief Lewis told the *Seattle Times* in August 2004.

Built in 1974 as a short-term holding facility, the 50-bed jail now holds inmates up to 18 months. Cells are brick boxes without bars, with small window and door slats. There are approximately seven or eight escapes a year, and the facility has had at least four suicides in its history, according to jail supervisor Ned Tillequots. "It's not set up for being a jail," he said. The detention center ordinarily has two officers on duty, and they are required to observe inmates every 30 minutes. But the jail was short-staffed the night of Mr. Sampson's death. He was being held on suspicion of violating a domestic violence, no-contact order, and housed in an isolation cell in the former juvenile wing. In May 2004, the facility was told by the BIA that it could no longer house juveniles.

There are approximately 74 tribal detention centers throughout the country, 20 of which are operated by BIA's Office of Law Enforcement Services (OLES); 46 jails receive BIA funding for detention services, and 8 facilities are operated by tribes. For many years, the BIA detention program has been characterized as drastically under-staffed, under-funded, and poorly managed.

Ironically, the suicide of Ricky Owens Sampson came only two days after the U.S. Senate's Committee on Indian Affairs held hearings regarding conditions of confinement in BIA-run detention facilities. The June 23 senate hearing was called after alarms were raised in newspaper stories and in a 10-minute videotape of jails on Montana reservations made by Ed Naranjo, formerly the BIA's agent in charge of law enforcement in six western states. The videotape showed physical decay, faulty plumbing, overcrowding, a volatile mix of juvenile and adult inmates, and inadequate security measures most facilities.

"Please look at the video, and maybe you will understand," the committee was told by Fred Guardipee, a former law enforcement officer now on the Blackfeet Tribal Business Council in Browning, Montana. He said the Blackfeet jail ran out of money when the tribe operated the facility, deteriorated when the BIA took it over, and now has to boil its water to make it safe enough for drinking.

The problem extends far beyond Montana, stated Hope MacDonald-Lonetree, chairwoman of the Navajo Council's public safety committee. The Navajo nation's large reservation has 33,000 arrests a year, but its only adult jail is a 103-bed facility, so decrepit that environmental and health regulations sometimes reduce its capacity to 60 inmates. "Inmates are often kept in the back of a police car because there's no room for them," she said. "We cannot separate the abuser from the victim, and the abusers know that."

By far, the most damning testimony at the senate committee hearing came from Earl Devaney, Inspector General for the Interior Department. "BIA's detention program is riddled with problems and, in our opinion, is a national disgrace with many facilities having conditions comparable to those found in Third World countries," he bluntly stated. "Unfortunately, BIA appears to have had a 'laissez-faire' attitude in regard to these horrific conditions at its detention facilities."

Beginning in September 2003, Inspector General Devaney's office has inspected 27 of the 74 detention facilities. In April 2004, the his office issued an interim ereport entitled "Indian Country Detention Facilities." The investigative report documented widespread problems regarding general conditions of confinement in those inspected BIA facilities. A final report, expected to be released within the next few months, will offer recommendations regarding funding, detention standards and policies, facility maintenance, health care and social services, and hiring and training protocols for detention personnel.

Inspector General Devaney's testimony (which is reprinted below) included numerous examples of suicides and other deaths within the detention facilities. Senator Ben Nighthorse Campbell, who chairs the Committee on Indian Affairs, cringed when the inspector general stated that his office had found 2 reported and 39 unreported suicide attempts at the BIA jail in Lame Deer, Montana, on the Northern Cheyenne Reservation. "I am a member of the tribe, and I didn't know," said Senator Campbell, the only American Indian in Congress. He lives in Colorado with the Southern Ute Indian Tribe, which got so upset by conditions at its BIA-run jail that it did what less prosperous tribes could never afford — they used a tax-exempt bond issue to build a $9-million justice center that includes a 55-bed detention facility.

At the conclusion of hearing, Senator Daniel Inouye, the committee's vice chairman who has been in Congress since 1959, stated that "this has been the most depressing hearing I have ever participated in."

Testimony of the Honorable Earl E. Devaney,
Inspector General for the Department of the Interior,
Before the Committee on Indian Affairs,
United States Senate, June 23, 2004

Mr. Chairman and members of the Committee, I want to thank you for the opportunity to address the Committee this morning concerning the state of detention facilities in Indian Country.

In September of 2003, my office began an assessment of Indian Country detention facilities. I initiated this assessment following a conversation with the Chair of the Attorney General's Advisory Committee on Indian Country, United States Attorney for the District of Minnesota, Thomas Heffelfinger, who had expressed

his general concerns to me about the overcrowding and poor conditions of Indian Country jails. I then discovered that these same concerns had been articulated for years by the Department of Justice in numerous reports. My office had also been receiving unofficial reports of appalling conditions at the detention facilities in Indian Country. With all this information, I felt compelled to address these concerns immediately.

We selected a team of seasoned investigators and auditors to visit a predetermined number of facilities and collect information about their management and operation. Our focus was on whether the funds designated for Indian Country detention facilities were being properly expended and whether these facilities were safe and secure.

I would like to point out that we began our assessment well before the confirmation of the present Assistant Secretary for Indian Affairs, and prior to any of the recent media disclosures of allegations made by a former BIA law enforcement official.

While we have completed all our planned site visits, we have not finished our analysis of the funding issues or BIA's management of the Detention Program. However, given the Committee's interest in this issue, I will gladly summarize our findings, thus far, and share with the Committee the same concerns I shared with Secretary Norton in April of this year when I gave her an interim report on the deplorable conditions we were finding at some of these facilities. Thus, my report to her then and to you today, focuses primarily on deaths, attempted suicides, escapes of inmates and officer safety issues. While we have visited only 27 of the 74 detention facilities in Indian Country, we assume that similar incidents have occurred at other detention facilities. Therefore, we believe it is imperative that BIA takes immediate action to alleviate these potentially life-threatening situations at all Indian detention facilities.

Under the Indian Law Enforcement Reform Act of 1990, BIA is required to provide law enforcement services on reservations. In addition, under the Indian Self-Determination Act, BIA provides funding to tribes for detention services. Of the 74 detention facilities in Indian Country, 20 are operated by BIA's Office of Law Enforcement Services (OLES), 46 receive BIA funding for detention services under Public Law 96-638, and 8 are operated by tribes. Of the 74 facilities, 28 house adult inmates, 11 house juveniles, and 35 house a combination of both adults and juveniles.

For many years the BIA detention program has been characterized as drastically under-staffed, under-funded, and poorly managed. BIA's Director of Law Enforcement has oversight authority for BIA-operated and 638-contract detention facilities. Until very recently the Director oversaw these facilities through six district commanders and with a three person detention staff at OLES Headquarters.

In most of the facilities we have visited, basic jail administration procedures are not followed and many detention managers and their staff have not received professional, certified training in detention procedures. In fact, BIA OLES officials admitted to us that none of their detention facilities "come close" to meeting BIA's standards for operation, which derive from nationally recognized detention standards. BIA's detention program is riddled with problems and, in our opinion, is a national disgrace with many facilities having conditions comparable to those found in third-world countries. Unfortunately, BIA appears to have had a "laissez-faire" attitude in regard to these horrific conditions at its detention facilities.

Based on our visits, we discovered that serious incidents are not always communicated up the chain of command. Our review of the Serious Incident Log maintained by the OLES detention program and a similar log kept by the OLES internal affairs unit revealed that many of the incidents we identified occurring within the last three years were not contained in these logs. In fact, during this three year time frame we found close to 500 serious incidents – including deaths, suicide attempts and escapes – that were either undocumented or not reported to the BIA/OLES.

The following are some examples of the serious situations we have identified so far in our assessment.

Deaths and Suicides

We learned of ten deaths from the facilities we visited. Five of these deaths were suicides and five were non-suicides. Inexplicably, only 5 of these deaths had been reported to OLES. Among those deaths reported to OLES is the recent death of a 16-year old student who died while in a detention cell at the Chemawa Indian School in Oregon. BIA operates the Boarding School which has a detention facility. This case is under active investigation by my office in conjunction with the U. S. Attorney in Portland, Oregon.

In March 2003, a 15-year-old inmate hanged herself at the BIA-operated Zuni Adult and Juvenile Detention Facility in New Mexico. According to the facility director, correctional officers at the time were "off-line for approximately 30 minutes," handling other duties, and were not properly overseeing the cell population. Similarly, at the BIA-operated Hopi Adult and Juvenile Facility in Arizona, an intoxicated inmate died of asphyxiation in 2003. According to the Acting Lead Correctional Officer, this occurred because the two officers on duty were "more interested in cleaning up the office" than observing inmates.

Attempted Suicides

Based on our findings, suicide attempts appear to be a regular occurrence at many of these facilities. At the BIA-run Northern Cheyenne Detention Facility in Montana there have been an alarming 41 suicide attempts within the last three years. Only 2 of those incidents were actually reported to the OLES. At many of the facilities, we found multiple suicide attempts made by the same inmate. For example, during 2001, an individual detained at the Shiprock facility in New Mexico attempted to hang himself seven times using articles of clothing or towels left in the cell. The correction officer's response was quite elementary — if the inmate tried to hang himself with his socks, they took his socks away; if he tried to hang himself with his towel, they took the towel away — until finally the inmate was left in his cell without any clothing.

Prisoner Escapes

For the most part, the correctional officers at these facilities convey stories of prisoner escapes with an air of casual inevitability. In fact, our impression is one of collective acceptance.

In our interviews, correctional officers who discussed escapes also told us that it is simply not possible to prevent inmates from escaping. Since the majority of these facilities often function with only a single officer on duty, officers explained that they simply cannot "keep an eye" on everyone. In addition, we found that some facilities do not notify local law enforcement of prisoner escapes. This is not only disconcerting, it is irresponsible to allow escaped prisoners to travel freely in a community and surrounding areas while the local law enforcement authorities have no information about their escapes.

Physically rundown and deplorably maintained, many of the facilities provide ample opportunity for escape. At one facility, the chain-link fence surrounding the outdoor recreation yard was held together and locked by a set of handcuffs because the inmates had learned the combination to the cipher lock on the gate. While many of the recreation yards at these facilities are fenced-in and crowned with barbed wire, there seems to be a universal acceptance among the correctional officers that if inmates want to climb over the fence and escape, they will.

From weakened and deteriorating locks on cell doors to broken windows in inmate dormitories, the interior of many of these facilities is in extremely poor condition and therefore does nothing to deter prisoners who set out to escape. For example, the wire-meshed windows in many of the cells at the White Buffalo Youth Detention Center in Montana are loosely encased in a crumbling wall and, with the application of some pressure, can be easily removed from their housing. According to the Acting Director at the detention center, these "removable windows" have, in the past, provided a vehicle of escape for a number of detained youths.

Perhaps even more disturbing than the actual circumstances and frequency of inmate escapes at these facilities are the lack of response and importance placed on these incidents by those working at the facilities, both correctional officers and facility directors, alike. At the Shiprock Adult detention facility in New Mexico, one officer chuckled in response to our question about escapes, and said, "Oh yeah, they happen." She then said that a prisoner had escaped from her in June 2003, on foot and in ankle-shackles while she was ushering a line of prisoners from the facility to the courthouse across the courtyard. Since she was the only officer on duty at the time, she said that she could not pursue the fleeing inmate and leave the other prisoners unattended. The officer told us that to the best of her knowledge that prisoner had not yet been apprehended.

Officer Safety

One of the most common problems we found while visiting these facilities is lack of staffing. In many cases, having only one correctional officer on duty per shift is not unusual; it is common practice.

At Mescalero in New Mexico, a female correctional officer was working alone when she was confronted at knife-point by a former inmate who entered the facility through an unlocked door. Tragedy was averted when the officer locked herself into a detention cell. An inmate at the jail convinced the intruder to leave the officer alone, while a second inmate summoned the police.

The San Carlos facility in Arizona has only four correctional officers on staff to operate what they feel is an overcrowded facility. To address this situation, the facility has placed a 24-hour, 7-day-a-week "lockdown" on inmates. Although lockdown is not unusual as a short-term solution for an acute problem in a detention facility, it could lead to an unsafe and dangerous environment long-term. At San Carlos, a detention officer on duty has no one for back up if a medical emergency or conduct problem arises. When an officer is working alone, he or she must either wait for assistance or act independently, both of which risk placing themselves or inmates in a potentially life-threatening situation.

At the Blackfeet facility in Montana, staff told us there is never more than one correctional officer on duty. Furthermore, twice a week, the officer on duty also functions as the facility cook to prepare inmates' meals, leaving the facility unsupervised during meal preparation time. At this same facility, one of the dispatchers said that her husband, a correctional officer at the facility, had been working alone and was attacked by an inmate. According to the dispatcher, the sound of the other inmates banging on doors was the only thing that alerted her to the incident and prevented a potential fatality. Unfortunately, this incident does not appear to be an exceptional case; the BIA district commander told us, "Every officer here has been assaulted."

Aside from a lack of officers on staff, the current officers at these facilities are, for the most part, poorly trained. This lack of training not only hinders the officers' ability to properly document incidents and follow standard procedures, but also leaves the officers unprepared to prevent physical harm that may be targeted against them or against inmates. In fact, one district commander stated, "We've never received any training on how to operate a detention facility." When asked if his facility followed BIA standards, the commander quipped, "Most BIA standards can't be met, so why even try?"

In addition to officer safety, the safety of the inmates themselves must be considered. Officers who are improperly trained or who have not undergone thorough background investigations may become a liability. Recently, a correctional officer working at the White Buffalo Youth Detention Center in Montana was convicted of raping a 17-year-old female inmate while transporting her from the facility to receive medical treatment.

During my discussion with the Secretary in April, I made a number of recommendations to her including instituting new reporting protocols and the prompt investigation by BIA of any serious incident such as those I have cited today. I was pleased by her immediate response to my briefing. Following our meeting, she tasked Associate Deputy Secretary James Cason along with Assistant Secretary David Anderson to begin addressing the concerns I raised. To assist them in this effort, she also made a request to DOJ for an experienced corrections professional from the Bureau of Prisons to be detailed to BIA. That person is now on board and I detect a new sense of urgency about these concerns at BIA.

Our final report, which we hope to have finished at the end of the summer, will provide the Department with additional findings and recommendations regarding funding, detention standards and

policies, detention facility maintenance, health care and social services at the detention facilities, and training and hiring practices of detention personnel. The responsibility for the conditions and failings we have found at Indian detention facilities can not be attributed to any particular individual or Administration. Some of these problems are decades old. Thus, the solutions will not be easy to achieve and may take considerable time, effort and funding. However, nothing less than a Herculean effort to turn these conditions around would be morally acceptable.

Editor's Note: On July 22, 2004, Senator Ben Nighthorse Campbell introduced legislation to provide broad-sweeping reforms to the Indian tribal detention facilities system. The bill, entitled the Indian Country Detention Facility Reform Act of 2004, would direct the Secretary of the Interior to create a new branch of detention services, establish clear lines of authority, and clear protocols for the reporting of deaths and other serious incidents. The legislation will be considered by the Senate when it reconvenes in the fall. ❑

News From Around the Country

Offered below are brief stories regarding inmate suicide, offenders with mental illness, and other related topics that have recently occurred and/or been reported throughout the country.

Louisiana

In June 2004, the city of Shreveport agreed to pay $3 million to the family of a woman who hanged herself in the city jail after allegedly warning staff she was going to commit suicide. Frances Loggins, 48-years-old, used her jail-issued pants to hang herself from a shower rod in July 2002. She had been arrested for public intoxication at a riverfront casino and apparently told jail staff she was going to commit suicide. She was found hanging 30 minutes following placement in a cell. Attorneys for the family had argued in a lawsuit that the city and its jail staff did not provide Ms. Loggins with a psychiatric assessment and failed to implement any suicide prevention measures.

In November 2003, the city paid $4.9 million — its biggest legal settlement ever — to settle a lawsuit filed by the family of a man who was severely beaten by another inmate. Carl Janski, 60-years-old, was also being held on charges of public intoxication. He died a month after the settlement was reached.

Maine

An eight-month-old crisis intervention program for training correctional staff at the Androscoggin County Jail in Auburn to calm inmates who may be in the throes of a mental health crisis is being looked at as a potential model for easing tensions in jails around the state. The state chapter of the National Alliance for the Mentally Ill (NAMI-Maine) plans to study the program's effectiveness by interviewing officers and examining jail records. Mental health advocates say that documenting the jail's success would be a first step toward persuading more facilities to adopt similar programs. "It's working," Lieutenant Michael Braun, the facility's assistant administrator, told the *Associated Press* in June 2004. "But we don't have an easy yardstick" to measure progress, he cautioned.

The Crisis Intervention Team (CIT) program began in December 2003 when 10 correctional officers were selected to receive 40 hours of classes including signs and symptoms of mental illness, substance abuse, psychotropic medications, and legal issues. Along with NAMI-Maine staff, clinicians from Tri-County Mental Health Services and St. Mary's Regional Medical Center taught the classes. In addition, officers toured local mental health agencies, and community providers toured the jail.

The focus of the training was on "de-escalation," calming situations in which someone may be threatening to harm himself or others. The aim was to change traditional responses in which officers either ignored sudden mood shifts or other unexplained behavior by inmates, or simply demanded that the behavior stop. Instead, officers were taught to patiently listen and effectively communicate with inmates experiencing possible mental health crises. If an inmate's behavior was suggestive of mental illness, a member of a crisis intervention team would be summoned to the facility. The newly trained correctional officers formed the CIT, and two of its members are on duty at all times. During the first six months of the program, the CIT was alerted 29 times, but only once did it have to use force. In that case, the inmate was banging his head against a cinder block wall, and he was temporarily placed in a restraint chair.

The Crisis Intervention Team program was first established several years ago by the Memphis Police Department. NAMI-Maine was instrumental in establishing a similar program within the Portland Police Department, and now within the Androscoggin County Jail.

For more information regarding the CIT program, contact NAMI-Maine, 1 Bangor Street, Augusta, Maine 04330, (207) 622-5767, or visit their website: http://me.nami.org

Illinois

Stricken with severe mental illness, Robin West was homeless off and on for more than 20 years, sleeping on CTA trains or at O'Hare International Airport. It was a dreadful life for the 46-year-old woman, and for Cook County taxpayers, it was dreadfully expensive.

Like many people in her predicament, West cycled repeatedly through Illinois' jail and prison systems, requiring tens of thousands of dollars in scarce resources. Between 1988 and 2000, West was arrested more than 75 times for offenses such as trespassing, panhandling, disorderly conduct and drug abuse, court records show. But for the last year and half, West has managed to stay housed and out of trouble, thanks to one of two small but promising programs that Illinois corrections officials say could help many of the state's homeless mentally ill.

The programs, run by Thresholds, a social service agency in Chicago that aids the mentally ill, use outreach workers to track severely mentally ill inmates released from Cook County Jail and a state prison in Downstate Dwight. The workers visit participants — every day in most cases — to make sure they stay on medication, stay off the streets and receive job training or disability payments. Officials are buoyed by a Loyola University Chicago study in 2001 that concluded that Thresholds' program reduced jail and hospital stays by more than 80 percent for the first 30 participants, saving the state and county more than $1 million in a year. The program for inmates released from Cook County Jail, begun in 1997, now has about 70 participants.

West joined in 2001. Living in Rogers Park, West said she is off drugs and, in the last 19 months, has had no trouble with police. "It's a very big change," West said. "But something had to change in my life. I was tired of going to jail."

The program at Dwight Correctional Center is in its infancy, with 12 participants. But it, too, has impressed state officials. "They've taken people who have been back and back and back into the system...and they've really had some wonderful success stories," said Amy Ray, acting manager of mental health for the state Department of Corrections. This month, a coalition that includes Thresholds staff and members of the John Howard Association, a prison reform group, will hold its first meeting. The coalition plans to look at issues surrounding the release of mentally ill inmates, including ways to expand or improve the Thresholds program.

One potential proposal would ease state privacy laws so an inmate's mental health records could be accessed by state mental health officials after the inmate is released. Mental health advocates lament that jails and prisons have become the nation's new psychiatric hospitals, warehousing people whose psychiatric conditions lead them to commit the same, often minor, offenses again and again. About 16 percent of jail and prison inmates have some type of mental illness, the U.S. Justice Department reported in 1999.

In theory, newly released inmates who received psychiatric medication in jail or prison should find a stable place to live, then promptly visit a mental health clinic to ensure that their treatment continues uninterrupted, said John Fallon, who directs the programs for Thresholds. In practice, severely mentally ill inmates may have a hard time finding housing. They may not have a clinic nearby or have good transportation. They typically have to wait 30 days for an appointment, Fallon said. Or the inmates simply may not be able to navigate the system. Leaving prison, "you've got, usually, $10," Fallon said. "You've got two weeks of medication and a phone number to a mental health clinic. These are people who have trouble finding their way to something a block and a half away. It's a hard road."

Without treatment, the former inmates can become overwhelmed by delusions, unreasonable fears or disorganized thoughts. They often commit the same offenses that got them locked up in the first place or use street drugs in an attempt to relieve their symptoms.

Ami Guerra, 43, of Chicago was selected for the jail program in 2000 after what she estimates to be at least 25 trips to jail and 25 stays in psychiatric hospitals over two decades. Diagnosed with schizophrenia as a teenager, Guerra was frequently homeless as an adult. After a shaky start in the jail program, Guerra has not been arrested in more than a year. "I had a rough road with [Thresholds staff] in the beginning," Guerra said. "I would go into these moods where I would walk the streets. They would look for me and find me [and say], 'Ami, get in the van. Where have you been?'...They never gave up on me."

On the streets, she was sometimes a crime victim, Guerra said. One beating left her with a long scar on her forehead. In the program, Guerra has her own apartment, takes medication and works as a janitor for a company associated with Thresholds. "I can think clearly," she said. "I can take care of myself. I can cook. I can clean.... I'm happy for a change."

Fallon promotes the programs as a good deal for taxpayers. Cost is about $1,000 per participant per month, he said. Keeping the same person at Cook County Jail for a month costs about $1,800, plus money for treatment. State prison costs run from about $1,800 per month for male inmates to $2,500 per month for women, prison officials said. A one-month stay at a state psychiatric hospital can cost $15,000 or more.

When starting the programs, Thresholds chose people whose illness had repeatedly led them to jail or state mental hospitals. One early participant had been arrested 135 times and spent about 400 days in jail and 10 years in state psychiatric hospitals over a 21-year period, Fallon said. Fallon estimated the total cost to the state and county for that person was about $1.5 million. Since joining the program five years ago, that former inmate has spent only 14 days in jail and has been to a private hospital once, for less than a month, Fallon said.

Fallon said more than 1,000 inmates in Cook County Jail take psychiatric medication on any given day. "We're really just taking an eyedropperful of folks who need this service," he said.

UPDATE
ON THE INTERNET

Recent issues of the ***Jail Suicide/Mental Health Update*** are now available on the Internet at:

www.ncianet.org/cjjsl.cfm

Check us out on the Web!
www.ncianet.org/cjjsl.cfm

Other jail/juvenile suicide prevention and jail mental health resources, including several recent articles by Lindsay M. Hayes, can be found at the following web sites:

www.hhpub.com/journals/crisis/1997
www.nicic.org/jails/defrault.aspx
www.ojp.usdoj.gov/managingoffenders/mentalhealth.htm
www.ncjrs.org/html/ojjdp/jjjnl_2000_4/sui.html
www.pbstandards.org/resources.aspx
www.gainsctr.com

West, meanwhile, is simply glad to be off the streets and proud of the new life she has begun to carve out for herself. "I spent more time in jail than I did out of jail. I don't plan on going back," she said.

The above article — "Mentally Ill Find Guidance After Jail: Program Targets Repeat Offenders" — was written by Michael Higgins, a staff writer for the ***Chicago Tribune****. Copyright (January 6, 2004), Chicago Tribune Company. All rights reserved. Used with permission.*

Editor's Note: We have previously spoken of the Thresholds Jail Program (see ***Jail Suicide/Mental Health Update****, Volume 9, Number 4, Summer 2000, pages 14-15). For more information, contact John Fallon, Director, Thresholds Jail Program, 4101 Ravenswood Avenue, Chicago, Illinois 60613, (773/880-6260, ext. 277), or visit their website: www.thresholds.org/jail.htm*

Indiana

An inmate who attempted suicide in the Delaware County Jail in Muncie and later died on March 5, 2004 became the first suicide victim in the facility's 12-year history. Or did he?

David J. Goodwin, 39-years-old, was unconscious when found by correctional officers on March 1 with a bed sheet tied around his neck and to a sink. He was pronounced dead four days later on March 5 at 1:24 pm in Ball Memorial Hospital, approximately two hours after family members authorized the removal of life-support devices.

However, Delaware County Sheriff George Sheridan does not consider Mr. Goodwin's death to be a jail suicide because the inmate had been revived by correctional officers and died several days later at the hospital. "It didn't occur in the jail. It was an attempted suicide here," Sheriff Sheridan told *The Star Press*. "You can't say it was a death in the jail. This was just another attempt." The sheriff continued: "It doesn't matter how good of a jail you run, there is always a potential for it to happen."

Mr. Goodwin had been recently sentenced to two 180-day contempt-of-court sentences after he referred to a judge by an obscene name during a child support hearing. During his first week of confinement, he was placed in isolation following an altercation with another inmate. When initially booked into the jail, Mr. Goodwin gave no indication that he was contemplating suicide. Following his suicide attempt, however, jail staff learned that he had an extensive history of suicidal behavior, the most recent of which was a suicide attempt six months earlier.

South Dakota

On July 19 2004, the United States Court of Appeals for the Eighth Circuit ruled that a woman whose son committed suicide in the Bennett County Jail in Martin can continue her lawsuit against former Bennett County Sheriff Russell Waterbury. The appeals court, however, dismissed other defendants in the case, including the state, county and two other sheriff's department employees.

Twylla Mae Turney filed the lawsuit (*Turney v. Waterbury*, et. al) after her son, 31-year-old Bill Turney, used a bed sheet to hang himself in the Bennett County Jail on October 23, 2001. She alleged that officials acted with deliberate indifference to his risk for suicide.

According to court records, Mr. Turney had been transferred from the 24-bed Bennett County Jail to the larger Pennington County Jail in Rapid City after he became violent and threatening to the facility's lone officer. On October 20, 2001, Mr. Turney attempted to hang himself with a bed sheet while in the Pennington County Jail. The attempt was thwarted by officers and the inmate was placed on suicide watch. Two days later on October 23, Mr. Turney was transferred back to the Bennett County Jail for a court hearing. Although his attorney had reached a plea agreement for him to serve a 15-year prison term for various offenses, Mr. Turney was fearful of returning to prison because he feared retaliation after recently providing information regarding a prison murder.

When Mr. Turney arrived back at the Bennett County Jail, Sheriff Waterbury was informed by Pennington County officials that the inmate had attempted suicide in their facility. Before Jailer Tracy Merchen could complete an intake screening form on Mr. Turney, the sheriff himself placed Mr. Turney in an isolation cell and told the jailer that she should check on the inmate every 10 minutes, but not to enter cell alone. The sheriff also said he told Chief Deputy Bruce McMillin to pay close attention to Mr. Turney that night, but the chief deputy denied that the sheriff had given him any such instructions.

At approximately 6:30pm on October 23, Mr. Turney asked Jailer Merchen if he could make a telephone call. The jailer told him she would have to call and have Chief Deputy McMillin come to the jail. Jailer Merchen made the telephone call and returned to the cell to find Mr. Turney hanging from a bed sheet tied to bars in the ceiling of the cell. She did not enter because the sheriff had told her never to enter the cell by herself. Jailer Merchen immediately call the sheriff at home. Sheriff Waterbury was sleeping at the time, so his wife answered the telephone and took a message for him to immediately call the jail. When the sheriff called the jail shortly thereafter, Jailer Merchen informed him that Mr. Turney was hanging. The sheriff hurried to the jail, entered the cell, cut the ligature from the victim's neck, and Mr. Turney dropped to the floor. Paramedics were summoned and transported the victim to local hospital where he was subsequently pronounced dead.

According to the United States Court of Appeals for the Eighth Circuit (Case No. 03-2375), the actions of McMillin and Merchen did not amount to deliberate indifference because the chief deputy was never informed that Mr. Turney was a suicide risk, and the jailer's failure to complete an intake form was negligent at best. However, the appeals court took a different view of Sheriff Waterbury's conduct. It stated, in part, that:

> Instead of allowing Merchen to fill out an intake form for Turney (a form which included questions about past suicide attempts), Waterbury brought Turney directly to his cell. He then ordered Merchen not to enter the cell alone under any circumstances. Although he told Merchen to keep Turney under a close watch, this order provided no protection to Turney since Merchen could not actually enter Turney's cell in the event of an emergency. Waterbury claims that he told McMillin to keep a close eye on Turney, but McMillin testified that this conversation never happened. In short, Waterbury's response to Turney's known suicide risk, which included not investigating the earlier attempt,

not permitting Merchen to complete Turney's intake form, placing Turney in a cell alone with a bed sheet and exposed ceiling bars, and ordering Merchen not to enter Turney's cell without backup — yet leaving her as the only official at the jail — are facts which exhibit deliberate indifference.

The case was referred back to the trial court for further proceedings with Sheriff Waterbury as the lone defendant.

Kentucky

As noted in the cover story of our last ***Update*** (Volume 12, Number 4, Spring 2004, pages 1-7), an ambitious bill was introduced in the state legislature to develop and fund a statewide array of innovations to reduce suicide and the risk related to mental illness in Kentucky jails. In the final hours of the Kentucky legislature, the bill sponsored by Senator Dan Kelly (R) passed with support from the leadership of the Democratic controlled House. It was signed into law by the governor on April 22, 2004.

The legislation provides for the development and implementation of the Kentucky Jail Mental Health Crisis Network. The $2.7 million funding for this program is covered by a five-dollar increase in criminal court costs. As detailed in our last issue, there are four components to this new service:

- Consistent screening instruments for the transporting police officer and the jail booking/ screening officer to identify inmates with suicidal behavior, mental illness, acquired brain injury and mental retardation;
- A Telephonic Triage service providing immediate 24-hour/365-day access to a Qualified Mental Health Professional for assessment of the risk identified in the jail screening process. The risk level is titrated to safe jail management protocols;
- Face-to-face mental health care to the inmates identified as being critical, high, or moderate risk in the Telephonic Triage process provided by the local Community Mental Health Center. The response time for the follow up service will be tied to the risk level; and
- A management information system tracking the data, providing quality controls and data report analysis related to reducing the rate of suicide and improving the care (and possible diversion) for persons with mental illness.

This service will be being implemented statewide in all interested jails over the next six months. The funding goes from the Kentucky Department of Corrections, through the Cabinet of Health Services, and to Bluegrass Regional MH-MR Board in Lexington, Kentucky. Bluegrass developed and is implementing this program with collaboration and consultation from Ray Sabbatine, a corrections consultant and former jailer of the Lexington-Fayette Urban County Detention Center. For more information, please contact Connie

Jail Mental Health Services Initiative from the National Institute of Corrections (Jails Division)

Nearly 6 to 8 percent of the more than 10 million annual commitments to jails are individuals with severe mental illnesses. Many sheriffs and jail administrators view the challenge of responding to the needs of this population as one of the major issues in jail management. In response, the National Institute of Corrections (NIC) has worked collaboratively with the National Institute of Mental Health for the past several years, and more recently, with the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services to increase and improve these services. As a result of these collaborations, the NIC Jails Division has developed a mental health initiative for jails.

An important component of the initiative is the offering of regional workshops conducted in collaboration with state, regional, and local jurisdictions. The 21-hour regional workshops will be provided upon request to help small and medium-sized jails enhance mental health services and service delivery for inmates. Several jurisdictions in a region can each send a three-person team consisting of a jail administrator, a representative of the jail's community mental health provider, and the person who coordinates mental health services for inmates. Each workshop will include: overview of the problem, planning principles, contract development, leadership and managing change, implementation strategies, staffing and cross-training, and coalition building. The workshops are conducted at the request of a host agency, which is responsible for furnishing the training rooms and equipment. The NIC Jails Division provides two trainers, the curriculum and training materials. Participants are responsible for their own expenses.

In addition to the workshops, the NIC Jails Division's mental health initiative includes the following services:

- **On-site Technical Assistance**: This assistance usually consists of an assessment of a jail system's mental health needs, *but also can be targeted at suicide prevention issues in the jail*;
- **Newsletter**: The NIC Jails Division funds the ***Jail Suicide/Mental Health Update***, a newsletter which is distributed free of charge on a quarterly basis;
- **Information Resources**: The NIC Information Center has compiled a jail mental health information resource order form that contains 22 items. The form is available at the mental health workshops held in Longmont, Colorado and at regional sites. It can also be obtained by calling the Information Center at (800) 877-1461.

For more information on the NIC Jails Division's mental health initiative, on-site technical assistance, and the mental health workshops, contact the agency at (800) 995-6429, or visit their website at: www.nicic.org

Milligan at cpmilligan@bluegrass.org or Ray Sabbatine at tykerjs@bellsouth.net.

Louisiana

A recent inmate suicide at the Orleans Parish Prison in New Orleans is not reason to reopen 35-year-old claims that the jail gives unconstitutionally poor care to mentally ill inmates, a federal magistrate ruled in June 2004.

The American Civil Liberties Union (ACLU) had contended that two deaths over the past three years — a suicide on April 4, 2004 and a death by dehydration in August 2001 — showed a pattern of poor care for inmates kept in restraints in the jail's psychiatric unit. Matthew Bonnette, 34-years-old, hanged himself even though his wrists were tethered to a belt and his legs were loosely restrained. Shawn Duncan, 24-years-old, died of dehydration after being strapped onto a bed for more than 42 hours.

The Orleans Parish Jail was the recipient of a class-action lawsuit in 1969, with one of the allegations being unconstitutional mental health services for inmates. The case has been litigated in federal court for many years and, in 1991, the court mandated in *Hamilton v. Morial* that Orleans Parish provide adequate mental health care.

Following Mr. Duncan's death in 2001, the ACLU had asked United States Magistrate Judge Alma Chasez to find that, based on his death, the jail's policy and procedures for using restraints on mentally ill inmates were unconstitutional. She refused, ruling that the ACLU had not shown any evidence that any other inmate was hurt while restrained.

In June 2004, Elizabeth Alexander, director of the ACLU's National Prison Project filed a 17-page motion in the case describing the Bonnette and Duncan deaths as "strikingly similar." The motion stated that both inmates were on suicide watch and in restraints for more than eight hours; neither man's medical records explained why doctors had ordered the restraints; records did not show whether either was regularly given food or drink, and inmates — not jail staff — found both bodies.

At a court hearing on June 9, Judge Chasez told ACLU attorney Elizabeth Alexander that "I can't keep reviewing, every time something goes wrong at the jail, the constitutionality of that policy. This case [*Hamilton*] involves systemic problems at the jail. Individual issues must be addressed by individual lawsuits." The judge ruled that as long as the Orleans Parish Prison maintains its accreditation from the National Commission on Correctional Health, it is meeting terms of court orders handed down in 1991 and 1992. In regard to the recent death of Mr. Bonnette, the judge informed ACLU attorney Elizabeth Alexander that "I've got to tell you, I would prefer that a new lawsuit be filed...rather than continue to have a 1969 lawsuit reopened." Vast volumes of records make the older lawsuit cumbersome, the judge told the attorney, and "I want something self-contained."

Attorney Alexander said after the hearing that she still hopes to prove that the earlier case should be reopened. "Congress has made it virtually impossible to file new suits" in such cases, she told the *Associated Press*. "I'm not saying I won't consider it."

Meanwhile, Robert Bonnette, father of the most recent victim, said he was thinking about suing the sheriff's office. "I'm not saying I'm a thousand percent certain," he said. "I'm going to discuss this. Pray about it. I've never filed suit against anybody in my life."

As noted in our last ***Update*** (Volume 12, Number 4, Spring 2004, pages 14-15), the family of Shawn Duncan had previously filed a lawsuit and that trial is currently scheduled for December 2004.

Georgia

The Decatur Police Department is changing its procedures following a recent inmate suicide. Jamell McKinnon, 18-years-old, who had been arrested on drug possession charges, was found hanging in a holding cell on May 15, 2004. The death was recorded by a closed circuit television (CCTV) monitor, but police officials have since acknowledged that staff were not monitoring the equipment as required. The new procedures will require that staff personally watch detainees and establishes a time frame by which detainees will be transferred to the DeKalb County Jail in Decatur.

The new procedures come as Mr. McKinnon's family tries to understand why he would have committed suicide, as well as why police department personnel did not prevent his death. "It's absurd that the police department is filming a teenager kill himself inside their own precinct," said Jesse Williams, the youngster's father. "The only thing that would have stopped Jamell from dying is someone paying attention to that tape," he told the *Associated Press* in July.

The police department conducted its own investigation and turned the results over to the Decatur city attorney and city manager. Police Chief Leander Robinson declined to say why department personnel were not monitoring the CCTV, citing the continuing investigation. He has requested that the Georgia Bureau of Investigation investigate Mr. McKinnon's death to determine if there was any criminal wrongdoing, and is also exploring the feasibility of hiring additional staff to monitor the CCTV equipment.

Illinois

In March 2004, a Randolph County Coroner Jury ruled that a Menard Correctional Center inmate's death on Christmas Day 2003 from hypothermia was "accidental," brought on by his confinement without clothing in an unheated cell. The ruling by a six-member jury followed the testimony of two witnesses that was elicited by Randolph County Coroner Neil A. Birchler.

At the time of his death, 31-year-old Charles Platcher had served 17 months of a 40-year sentence for the 2001 stabbing death of his mother and the attempted murder of her companion. Richard Harrington Jr., a state Department of Corrections investigator, testified that Mr. Platcher was confined in the prison's health care unit on December 15, 2003. A psychiatrist had recommended transfer to the unit after Mr. Platcher fought with his cellmate and assaulted several staff members. Two days later, he threatened suicide. Investigator Harrington stated that during all but two days of Mr. Platcher's confinement in the health care unit, he was under a "strip-cell suicide watch," meaning that the inmate was stripped of all clothing and bedding except for a single "suicide" blanket.

Pursuant to departmental policy, Mr. Platcher was checked every 10 minutes by an officer who looked into his cell through a viewing window. According to both correctional and medical staff, when offered a meal and/or medication, Mr. Platcher would "wave them off." At approximately 9:40 pm on December 24, 2003, Mr. Platcher was observed lying nude on the floor of his cell without a blanket. Several hours later at 3:30am on December 25, staff tried to awaken Mr. Platcher by calling to him through an access slot in the door, but found him "semi-unresponsive. He could only grunt at that time," Investigator Harrington told the coroner's jury. "They took that as a refusal of his meds." At approximately 8:30 am, medical staff finally entered the cell and found Mr. Platcher unresponsive with fixed and dilated pupils. Resuscitation efforts were started immediately, as were efforts to warm his body. Mr. Platcher was taken to a local hospital and subsequently pronounced dead.

Investigator Harrington arrived at Mr. Platcher's cell approximately five hours after the inmate had been taken to the hospital. He said the temperature inside the cell was about 60 degrees, while the outdoor temperature was 26 degrees. The investigator testified that he was told by prison personnel that two valves in the heating unit had malfunctioned, leaving the entire third floor without heat. However, Investigator Harrington stated, "They said Platcher never complained about the heat."

Randy W. Dudenbostel, chief deputy coroner, testified he was notified of Mr. Platcher's death at 12:40 pm. He said the inmate had a body temperature of 84.6, and he noted several bruised areas on Mr. Platcher's body. The bruises, he said, were consistent with Mr. Platcher's medical records pertaining to previous fights and medication injection sites. According to the deputy coroner, a forensic pathologist later determined that Mr. Platcher's death was from hypothermia "caused by his incarceration in a cell with no heat."

Sergio Molina, a spokesperson for the Department of Corrections told *The Southern Illinoisan* that "we began an investigation immediately upon the discovery of Charles Platcher in his cell and we have taken disciplinary action with regards to several employees in relation to this incident." It was believed that one nurse was fired, and another nurse and an officer were disciplined after the investigation into Mr. Platcher's death.

Georgia

In June 2004, the U.S. Justice Department announced that it had filed a lawsuit challenging the conditions of confinement at Terrell County Jail in Dawson. The lawsuit, filed in the U.S. District Court for the Middle District of Georgia, alleged that conditions at the facility routinely and systemically deprived inmates of federally protected rights. "When a jurisdiction refuses to take appropriate steps to address violations of constitutional rights, and flouts its agreements to do so, the Department of Justice will move aggressively to protect those rights," R. Alexander Acosta, Assistant Attorney General for Civil Rights, stated in a press release dated June 7.

The complaint alleged that the jail routinely violated federally protected rights, including failing to protect inmate safety, failing to provide required medical and mental health care, and failing to provide sufficiently sanitary living conditions. The Civil Rights Division's lengthy and detailed investigation revealed evidence of a number of serious violations of federally protected rights at the jail. For example, after jail officials allegedly left one detainee, with known mental health problems, unsupervised despite his being on "suicide watch," he hanged himself with his bed sheet.

Terrell County previously entered into a voluntary settlement agreement that would have remedied the illegal conditions identified at the jail. However, the Justice Department now alleges that Terrell County failed to live up to the terms of that agreement, which necessitated the filing of this lawsuit. Additional information about the Special Litigation Section of the Justice Department's Civil Rights Division can be found at www.usdoj.gov/crt/split/index.html.

Michigan

An independent investigation into the January 2004 death of a Muskegon County Jail inmate concluded that deputies acted appropriately before and after 24-year-old Bairo Gonzalez-Chavez was discovered hanging in his cell. The report, however, did not directly address whether the inmate, who had repeatedly said he wanted to die, should have been on suicide precautions. The investigation by the Michigan Sheriff's Association was conducted at the request of Muskegon County Sheriff George Jurkas.

On January 6, 2004, Mr. Chavez was sentenced to a total of up to 42 years in prison after being convicted of charges stemming from a March 2003 standoff at an apartment complex. Mr. Chavez had shot his girlfriend four times and also fired a shot from an apartment window during the 3-1/2-hour standoff with police. Just two days before his death, Mr. Chavez pleaded "no contest" to additional felony charges in connection with an attack on a courtroom deputy. The sentence from that conviction would have meant even more prison time.

At approximately 10:40 pm on January 14, Mr. Chavez was found hanging from a bed sheet in his maximum security cell. Cardiopulmonary resuscitation was started immediately by jail staff and continued until paramedics arrived. The last check of Mr. Chavez's cell had occurred at 10:08 pm. According to investigators, the closed circuit television (CCTV) camera in the cell went dark at 10:18 pm. Sheriff Jurkas stated that Mr. Chavez had covered the camera lens with some type of greasy substance. The sheriff's association report noted that the camera in the cell was operational, but the lighting and picture quality was so poor that it was unlikely that jail staff would have seen the hanging even if Mr. Chavez had not covered the camera lens.

Sheriff Jurkas said that he had requested the independent investigation to determine if his jail staff was involved in any type of assault or mistreatment of the inmate. The investigators were not asked to determine whether Mr. Chavez should have been placed on suicide watch, he said. The sheriff's association report said there was no indication of any outside involvement by staff or inmates in the inmate's death. "Standard operating procedures were followed by jail staff," the report concluded. The evidence indicated, however, that Mr. Chavez "was upset at the reality of going to prison and had contemplated suicide and/or escape prior to the hanging."

Although the sheriff's association report touched upon the fact Mr. Chavez had made prior suicide threats and questioned

procedures, it did not offer a conclusion as to whether the inmate should have been placed under a suicide watch. It did note, however, that a jail sergeant ignored a documented request from a jail nurse to put Mr. Chavez on suicide precautions the day of his sentencing (January 6) — eight days before his death. According to Sheriff Jurkas, Mr. Chavez was taking psychotropic medication and assessed by a community mental health worker seven times during his confinement, the last time on December 11, 2003 when he was cleared to return to the jail population.

"It's a balancing act," Sheriff Jurkas told the *Muskegon Chronicle*. "We have to balance the officers' safety against that of the individual." The sheriff said he did not think that Mr. Chavez's death was preventable. "We were more worried about him hurting someone else rather than himself," the sheriff said.

Kansas

The Kansas Bureau of Investigation (KBI) is currently reviewing six inmate deaths that have recently occurred in county jails and prisons throughout the state, and an official is concerned that a new law requiring such review is placing unexpected demands on the agency. "Given limited resources, we want to use our resources appropriately," Kyle Smith, a KBI special agent and the bureau's spokesman, told the *Associated Press*. Agent Smith said the "rash" of deaths was somewhat unexpected and opined that it was difficult to determine the cost of conducting each review and agents were currently investigating the deaths as part of normal duties.

Two inmates have recently died within four days of each other in the Sedgwick County Jail in Wichita, one in the Shawnee County Jail in Topeka, one in the Sumner County Jail in Wellington, and two in the state prison system. Agent Smith stated the investigations were continuing and included toxicology reports from the KBI lab.

Effective July 1, 2004, the new law requires that "whenever the death of a prisoner in the custody of a city or county and residing in jail or in a facility contracted through the city or county, or both, occurs, an investigation regarding the circumstances of the death shall be initiated by the Kansas Bureau of Investigation. A report of the findings of the investigation shall be made available to the chairperson of the senate judiciary committee and the house corrections and juvenile justice committee of the Kansas legislature and shall be subject to the open records act."

The KBI supported the new law. "There may be some valuable lessons (in reviewing the deaths)," Agent Smith stated. "We have to look at them." The agent stated, however, that if the demands on the KBI continued it may be appropriate to revisit the law, such as modifying it to allow for exceptions when the death is clearly of natural causes.

Sonny Scroggins, a human rights activist from Topeka who helped conceive of the new law following a rash of inmate deaths in the Shawnee County Jail during 2002 and 2003, said he was pleased the law was working, but hoped any modifications would not create a loophole where officials could categorize deaths liberally as natural causes. "I understand what he's saying," Mr. Scroggins told the *Associated Press*. "I think that's reasonable, but we need to be as open to the public as possible about what happened." ❑

JAIL SUICIDE/MENTAL HEALTH UPDATE

This technical update, published quarterly, is part of the National Center on Institutions and Alternatives (NCIA)'s continuing efforts to keep state and local officials, individual correctional staff, mental health/medical personnel, and interested others aware of developments in the field of jail suicide prevention and jail mental health services. Please contact us if you are not on our mailing list. Readers are encouraged to offer opinions and/or submit pertinent materials for inclusion into future issues.

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AVAILABLE JAIL/PRISON/JUVENILE SUICIDE PREVENTION MATERIALS

And Darkness Closes In...National Study of Jail Suicides (1981)
National Study of Jail Suicides: Seven Years Later (1988)
Training Curriculum on Suicide Detection and Prevention in Jails and Lockups—Second Edition (1995)
Curriculum Transparencies—Second Edition (1995)
Prison Suicide: An Overview and Guide to Prevention (1995)
Juvenile Suicide in Confinement: A National Survey (2004)
Jail Suicide/Mental Health Update (Volumes 1-12)

For more information regarding the availability and cost of the above publications, contact either:

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