JAIL SUICIDE/MENTAL HEALTH UPDATE

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JAIL STANDARDS AND SUICIDE PREVENTION: ANOTHER LOOK

*The relationship between suicide prevention and jail standards has been previously addressed in the **Jail Suicide/Mental Health Update** several times, most recently in 1996. Since that time, several organizations that promulgate national jail standards have published subsequent editions, and numerous states have revised their own standards. The question is, do these jail standards contain adequate provisions for suicide prevention? In revisiting this issue again, we present another review a national correctional standards for jail facilities, as well as a report card of state jail standards.*

NATIONAL STANDARDS FOR JAIL SUICIDE PREVENTION

Beginning in the early 1960s and continuing today, various legislative bodies and agencies have examined jail systems in an effort to fashion standards for the efficient operation of their correctional facilities. From these efforts, two basic types of standards have emerged to measure the adequacy of jail conditions: 1) the minimum standards of constitutional decency devised and refined by federal courts in decisions challenging the conditions of confinement, and 2) the growing body of self-regulatory standards and accreditation procedures promulgated by professional and federal agencies to stimulate facility improvement through voluntary, administrative action.[1]

Prior to the enactment of the Prison Litigation Reform Act of 1996, courts had traditionally taken an active role in measuring the adequacy of jail systems. Although correctional standards in general are not legally binding and do not set constitutional requirements,[2] the U.S. Supreme Court has stated that such standards have the ability to serve as guidelines or benchmarks in assessing the "duty of care" or "reasonable conduct."[3] Jail standards have become a yardstick for measuring conditions of confinement. As noted several years ago, "The new judicial activism has added a sense of urgency to the development of increasingly *specific self-regulatory standards* by executive and professional organizations. In turn, the availability of these standards promises to introduce a new level of objectivity to litigation challenging the conditions of confinement."[4]

A study to determine the impact of the American Correctional Association (ACA)'s correctional standards on court rulings found that 1) courts often consult ACA standards when attempting to determine appropriate expectations in a correctional setting; 2) courts sometimes cite ACA standards as the basis for establishing a court standard or a requirement in a decision; and 3) courts have sometimes utilized ACA standards and accreditation as a component of a continuing order or consent decree.[5]

Not all courts use standards (ACA or otherwise) to measure conditions of confinement, however, because in "many instances, a lower requirement is adopted consistent with the court's view of the constitutional or statutory requirement. In others, a higher standard might be established by the court given the circumstances of the case. And often the court prefers to take a totality of conditions perspective instead of relying on specific standards."[6] As noted elsewhere in this ***Update*** issue (see pages14-16), one appeals court recently opined: "…it is absurd to suggest that the federal courts should subvert their judgment as to alleged Eighth Amendment violations to the ACA whenever it has relevant standards. Additionally, the ACA's limited inspections are not to be binding as factual findings on the magistrate or on this court. While compliance with ACA standards may be a relevant consideration, it is not *per se* evidence if constitutionality."

In attempting to manage a correctional facility, the jail administrator is faced with two dilemmas: what constitutes sound correctional practices and what represents best practice. Correctional standards, whether state regulated or offered nationally, can provide guidance for the administrator. When devising a strategy to reduce liability, for example, the administrator can cite compliance with national and/or state regulated standards as part of a good faith defense. Because standards reflect a minimally acceptable standard

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of care, they provide reasonable guidelines on which the administrator can base policies and procedures. As aptly stated in the preface to the jail standards of one state's jail standards — "It is intended for the standards to serve as a catalyst for sheriffs and jail administrators to reexamine existing policies, procedures, and practices, and to aid in policy planning development, modification, and/or validation. The standards may also assist jail officials: a) to create greater uniformity in the operation and management of facilities; b) by serving as a resource for internal audits; and c) as a guide to developing lesson outlines for training.[7]

Reviewing the National Standards

During the past 20 years, numerous organizations have promulgated national standards for use in jail facilities.[8] However, the infusion of suicide prevention provisions into these standards is a fairly recent phenomenon, with great variation as to its specificity. In fact, several standards have failed to even address the issue of suicide prevention.[9] We have previously reviewed the provision of suicide prevention protocols in national standards for county jails, city jails, and police department lockups.[10] Offered below is another look at this issue.

American Correctional Association

The American Correctional Association's *Standards for Adult Local Detention Facilities* are the most widely recognized national jail standards, but, because their primary emphasis is on the operation and administration of jails, the early editions did not fully address health care. The second edition, published in 1981, included sections on the screening and supervision of suicidal inmates, health appraisals, as well as responding to medical emergencies.[11]

> 2-5174: Written policy and procedure require that all high and medium security inmates are personally observed by a correctional officer at least every 30 minutes, but on an irregular schedule. *More frequent observation is required for those inmates who are violent, suicidal* (emphasis added), mentally disordered or who demonstrate unusual or bizarre behavior.
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> 2-5273: Written policy and procedure require medical screening to be performed by health-trained staff on all inmates upon arrival at the facility. The findings are recorded on a printed screening form approved by the health authority. The screening process includes at least the following procedures...*Past and present treatment or hospitalization for mental disturbance or suicide* (emphasis added)...
>
> 2-5274: Written policy and procedure require that a health appraisal for each inmate is completed within 14 days after arrival at the facility. Health history and vital signs are collected by health trained or qualified health care personnel and all other data is collected only by qualified health care personnel. (Appraisal includes review of mental status.)

In addition, standard 2-5271 required the establishment of a training program to provide instruction in various areas, including "The ability to respond to health-related situations within four minutes...Administration of first aid and cardiopulmonary resuscitation (CPR)...Recognition of signs and symptoms of mental illness, retardation, emotional disturbance and chemical dependency." The Discussion section of standard 2-5271 included the following: "...If emergency treatment is not provided within four minutes in certain situations, lives can be lost. All correctional officers should have standard first aid training. Minimally, one health trained correctional officer per shift should be trained in cardiopulmonary resuscitation (CPR) and recognition of symptoms of illness most common to inmates."

In 1983, standard 2-5174 was revised to state:

> 2-5174: Written policy and procedure require that all high and medium security inmates are personally observed by a correctional officer at least every 30 minutes, but on an irregular schedule. More frequent observation is required for those inmates who are mentally disordered or who demonstrate unusual or bizarre behavior: *suicidal inmates are under continuing observation* (emphasis added).[12]

The following year, however, the requirement of a suicide prevention program was added to the standards, and it provided the strongest ACA commentary to date:

> 2-5271-1: Added August 1984. There is a written suicide prevention and intervention program that is reviewed and approved by a qualified medical or mental health professional. All staff with responsibility for inmate supervision are trained in the implementation of the program.
>
> DISCUSSION: Staff have a responsibility for preventing suicides through intake screening, identification, and supervision of suicide-prone inmates. They should receive special training in the implementation of a suicide prevention program.[13]

In January 1989, standard 2-5083 was revised to require that the topics of "signs of suicide risk" and "suicide precautions" be included in the training curriculum for new correctional officers.[14] In addition, standard 2-5273 was revised slightly to change "medical screening" to "medical, dental, and mental health screening." Also in 1989, the ACA published the *Standards for Small Jail Facilities*, developed for jails housing 50 or less inmates.[15] The manual incorporated standards 2-5174 and 2-5273 from the *Standards for Adult Local Facilities*, but did *not* require 2-5271-1 — detailing the written suicide prevention program.

In March 1991, the ACA issued the third edition of the *Standards for Adult Detention Facilities*. With a few exceptions, there were no substantial revisions in the suicide prevention protocols.[16] A more substantive change in the third edition, however, was standard 2-5174 (Supervision) being replaced by the following:

> 3-ALDF-3D-08: Written policy, procedure, and practice require that all *special management inmates* are personally observed by a correctional officer at least every 30 minutes on an irregular schedule. Inmates who are

violent or mentally disordered or who demonstrate unusual or bizarre behavior receive more frequent observation; *suicidal inmates are under continuous observation* (emphasis added).[17]

Further, while standard 2-5271-1 (Suicide Prevention and Intervention) had contained the ACA's strongest commentary regarding suicide prevention by emphasizing that "staff have a responsibility for preventing suicides...," that language was curiously removed from the third edition and the standard (renumbered as 3-ALDF-4E-34) was revised to read:

> There is a written suicide prevention and intervention program that is reviewed and approved by a qualified medical or mental health professional. All staff with responsibility for inmate supervision are trained in the implementation of the program.
>
> Comment: The program should include specific procedures for intake screening, identification, and supervision of suicide-prone inmates.

It should also be noted that standard 3-ALDF-1D-12 of the third edition also required all correctional staff to have *annual* instruction in both suicide prevention ("signs of suicide risk" and suicide precautions") and cardiopulmonary resuscitation.

Finally, in June 2004, the ACA released the fourth edition of its jail standards. Entitled *Performance-Based Standards for Adult Local Detention Facilities*,[18] the mandatory suicide prevention and intervention standard (4-ALDF-4C-32) of the volume states the following:

> A suicide-prevention program is approved by the health authority and reviewed by the facility or program administrator. It includes specific procedures for handling intake, screening, identifying, and supervising of a suicide-prone inmate and is signed and reviewed annually. The program includes staff and inmate critical incident debriefing that covers the management of suicidal incidents, suicide watch, and death of an inmate or staff member. It ensures a review of critical incidents by administration, security, and health services. All staff with responsibility for inmate supervision are trained on an annual basis in the implementation of the program. Training includes but is not limited to:
>
> - identifying the warning signs and symptoms of impending suicidal behavior;
> - understanding the demographic and cultural parameters of suicidal behavior, including incidence and variations in precipitating factors;
> - responding to suicidal and depressed inmates;
> - communicating between correctional and health care personnel;
> - using referral procedures;
> - housing, observation, and suicide-watch level procedures; and
> - follow-up monitoring of inmates who make a suicide attempt.

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 upcoming issue of the ***Update***, please send copies of your suicide prevention policy, screening/assessment forms utilized to identify suicidal inmates, and total number of suicides and your facility's average daily population for each year from 1995 thru 2004 to:

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Commission on Accreditation for Law Enforcement Agencies

In 1983, the Commission on Accreditation for Law Enforcement Agencies (CALEA) promulgated standards that included provisions for police department lockups and/or short-term holding facilities (not exceeding 72 hours). Released as a third edition in 1994, the *Standards for Law Enforcement Agencies* remained vague and non-prescriptive in terms of suicide prevention.[19] For example, although Chapter 72: (Holding Facility) required "receiving screening" (72.6.3), suicide risk inquiry was not specified, and there were no requirements for staff training in suicide prevention. In fact, only two CALEA standards were casually related to suicide prevention:

> 72.5.5: A written directive prescribes methods for handling, detaining, and segregating persons under the influence of alcohol or drugs or who are violent or self destructive.
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> Commentary: The holding facility is not normally equipped to provide treatment to persons under the influence of drugs or alcohol, and such persons should be detained in other facilities, when available. When these facilities are not available, special consideration should be given to ensuring that the potential for detainees to injure themselves or others is minimized. Such detainees should remain under *close observation* (emphasis added) facility staff.
>
> 72.8.1: A written directive requires 24-hour supervision of detainees by agency staff, including a count of the detainee population at least once every eight hours, and establishes procedures to ensure that the detainee is *visually observed* (emphasis added) by agency staff at least every thirty minutes.
>
> Commentary: ...Care should be taken during physical checks that the detainee does not anticipate the appearance of agency staff. Detainees who are security risks should be under closer surveillance and require *more frequent observation* (emphasis added). This classification includes not only detainees who are violent but also those who are suicidal or mentally ill or demonstrate unusual or bizarre behavior.[20]

The CALEA standards were again revised and released as a fourth edition in January 1999.[21] There were no meaningful changes made to the standards, other than the following "Commission Interpretation (March 22, 1996) — term 'Visually Observed': Agencies are encouraged, but not required, to introduce direct physical checks whenever possible, but detainees may be observed through audio/visual means." To date, the CALEA standards still do not directly address the issue of suicide prevention.

National Commission on Correctional Health Care

Jail standards of the National Commission on Correctional Health Care (NCCHC) provide the most comprehensive and practical guidelines for suicide prevention. First promulgated in 1987, NCCHC's *Standards for Health Services in Jails* not only required that jails develop a written suicide prevention plan (J-58), but also listed the 11 essential components to such a program: identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting, and review.[22] In addition, the 1987 edition offered other standards specifically related to suicide prevention, including J-20: Training for Correctional Officers, J-21: CPR Training, J-31: Receiving Screening, and J-34: Mental Health Evaluation.

The NCCHC standards were revised in 1992 and J-58 remained essentially intact although renumbered as J-54: Suicide Prevention.[23] The appendix of these revised standards also offered a four-level suicide prevention protocol for the assessment, housing and observation of suicidal inmates.[24] Briefly, *Level 1* is reserved for the inmate who has recently attempted suicide. The inmate should be housed in either a "safe room" or in the health clinic; with health care staff providing one-on-one constant observation to the inmate while they are awake, and visual checks every 5 to 10 minutes while the inmate is asleep. *Level 2* is reserved for the inmate who is considered a high risk of suicide. The inmate should be housed in either a "safe room" or in the health clinic; with health care staff providing visual observation of the inmate every 5 minutes while awake and every 10 minutes while asleep. *Level 3* is reserved for the inmate who is assessed as being a moderate risk of suicide, and may have previously been on either Level 1 or 2. The inmate should be observed every 10 minutes while awake and every 30 minutes while asleep. *Level 4* is reserved for the inmate that, perhaps based upon past history, may be at risk of becoming severely depressed and/or suicidal. The inmate should be observed every 30 minutes while awake and asleep.

NCCHC released the third edition of *Standards for Health Services in Jails* in 1996.[25] In addition to updating the four-level suicide prevention protocol, the standards offer two sample intake screening forms for identifying suicide risk.[26] As shown below, J-54: Suicide Prevention was revised to include several changes (including a new provision for "critical incident debriefing") and renumbered as J-51: Suicide Prevention. (Substantive changes from prior editions are underlined.)

J-51: Suicide Prevention

> Written policy and defined procedures require, and actual practice demonstrates, that the jail has a program for identifying and responding to suicidal individuals. The program components include identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting, review, and critical incident debriefing.
>
> **Discussion.** While inmates may become suicidal at any point during their stay, high-risk periods include the time immediately upon admission to a facility (especially if inmates are intoxicated from alcohol or other drugs); after adjudication, when the inmate is returned to a facility from court; following the receipt of bad news regarding self or family (such as serious illness or the loss of a loved one); and after suffering some type of humiliation or rejection. Individuals who are in the early stages of recovery from severe depression may be at risk as well.
>
> Key components of a suicide prevention program include the following:

1) **Identification.** The receiving screening form should contain observation and interview items related to the inmate's potential suicide risk.

2) **Training.** All staff members who work with inmates should be trained to recognize verbal and behavioral cues that indicate potential suicide. The plan should include initial and subsequent training.

3) **Assessment.** This should be conducted by a qualified mental health professional, who designates the inmate's level of suicide risk.

4) **Monitoring.** The plan should specify the facility's procedures for monitoring an inmate who has been identified as potentially suicidal. Regular, documented supervision should be maintained.

5) **Housing.** A suicidal inmate should not be housed or left alone. An appropriate level of observation must be maintained. If a sufficiently large staff is not available that constant supervision can be provided when needed, the inmate should not be isolated**.** Rather, s/he should be housed with another resident or in a dormitory and checked every 10-15 minutes. An inmate assessed as being a high suicide risk always should be observed on a continuing, uninterrupted basis or transferred to an appropriate health care facility. The room should be as nearly suicide-proof as possible (i.e., without protrusions of any kind that would enable the inmate to hang him/herself).

6) **Referral.** The plan should specify the procedures for referring potentially suicidal inmates and attempted suicides to mental health care providers or facilities.

7) **Communication.** Procedures should exist for communication between health care and correctional personnel regarding the status of the inmate.

8) **Intervention.** The plan should address how to handle a suicide in progress, including appropriate first-aid measures.

9) **Notification.** Procedures should be in place for notifying jail administrators, outside authorities, and family members of potential, attempted, or completed suicides.

10 **Reporting.** Procedures for documenting the identification and monitoring of potential or attempted suicides should be detailed, as should procedures for reporting a completed suicide.

11) **Review.** The plan should specify the procedures for medical and administrative review if a suicide or a serious suicide attempt (as defined by the suicide plan) does occur.

12) **Critical incident debriefing**. Responding to and/or observing a suicide in progress can be extremely stressful for staff and inmates. The plan should specify the procedures for offering critical incident debriefing to all affected personnel and inmates.

The most recent edition of the NCCHC's *Standards for Health Services in Jails* was released in 2003.[27] This volume provides more clarity for the measurement of compliance. Although the suicide prevention requirements remain essentially unchanged, as detailed below, the narrative is more sharply focused:

> Key components of a successful suicide prevention program include the following:
>
> 1) **Training.** All staff members who work with inmates are trained to recognize verbal and behavioral cues that indicate potential suicide, and how to respond appropriately. Initial and biennial training are provided, although annual training is highly recommended.
>
> 2) **Identification.** The receiving screening form contains observation and interview items related to the inmate's potential suicide risk. If a staff member identifies someone who is potentially suicidal, the inmate is placed on suicide precautions and is referred immediately to mental health staff.
>
> 3) **Referral.** There are procedures for referring potentially suicidal inmates and those who have attempted suicides to mental health care providers or facilities. The procedures specify a time frame for response to the referral.
>
> 4) **Evaluation.** An evaluation, conducted by a qualified mental health professional, designates the inmate's level of suicide risk, level of supervision needed, and need for transfer to an inpatient mental health facility or program. Patients are reassessed regularly to identify any change in condition indicating a need for a change in supervision level or required transfer or commitment. The evaluation includes

procedures for periodic follow-up assessment after the individual's discharge from suicide precautions.

5) **Housing.** Unless constant supervision is maintained, a suicidal inmate is not isolated. Rather, he or she is housed in the general population, mental health unit, or medical infirmary, and placed in close proximity to staff. All cells or rooms housing suicidal inmates are as suicide-resistant as possible (e.g., without protrusions of any kind that would enable the inmate to hang himself/herself).

6) **Monitoring.** There are procedures for monitoring an inmate who has been identified as potentially suicidal. Regular, documented supervision should be maintained, usually every 15 minutes or more frequently if necessary. While there are several protocols for monitoring suicidal inmates, when any actively suicidal inmate is housed alone in a room, supervision through continuous monitoring by staff should be maintained. Other supervision aids (e.g., closed circuit television, inmate companions or watchers) can be used as a supplement to, but never as a substitute for, staff monitoring.

7) **Communication.** Procedures for communication between health care and correctional personnel regarding the status of the inmate are in place to provide clear and current information. These procedures also include communication between transferring authorities (e.g., county facility, medical/psychiatric facility) and facility correctional personnel.

8) **Intervention.** There are procedures addressing how to handle a suicide in progress, including appropriate first-aid measures.

9) **Notification.** Procedures are in place stating when correctional administrators, outside authorities, and family members are notified of potential, attempted, or completed suicides.

10) **Reporting.** Procedures for documenting the identification and monitoring of potential or attempted suicides are detailed, as are procedures for reporting a completed suicide.

11) **Review.** There are procedures for medical and administrative review of a suicide or a serious suicide attempt (as defined by the suicide plan) does occurs. See J-A-10 Procedure in the Event of an Inmate Death for Details on these processes.

12) **Critical incident debriefing**. The facility specifies the procedures for offering timely critical incident debriefing to all affected personnel and inmates. Critical incident debriefing is a process whereby individuals are provided an opportunity to express their thoughts and feelings about a critical incident (e.g., suicide attempt, suicide), develop an understanding of critical stress symptoms, and develop ways of dealing with those symptoms.

A "Guide to Developing and Revising Suicide Prevention Protocols" is included in the appendices to NCCHC's 2003 standards, and is also included in the organization's *Correctional Mental Health Care: Standards and Guidelines for Delivering Services*.[28]

American Psychiatric Association

In 1989, the American Psychiatric Association released a task force report of guidelines for psychiatric services in jails and prisons.[29] Despite its boast that the "guidelines developed here go beyond the NCCHC standards by providing greater specificity concerning mental health services," the task force report was for more noteworthy for its failure to address any basic suicide prevention protocols. In 2000, the APA released a second edition of its guidelines, a far more comprehensive volume.[30] This time, the guidelines included a section devoted to suicide prevention that mirrored the NCCHC standards.

Conclusion

Historically, national correctional standards have been viewed with some skepticism, referred to as too general or vague, lacking in enforcement power, and often politically-influenced. As one observer noted in reviewing the historical record of national standards for correctional health care — "Courts and correctional administrators seeking specific guidelines as to what constituted 'adequate' provisions for health care were not likely to derive much satisfaction from the early standards."[31] And formal adoption of current national standards by a jail system does not necessarily ensure that individual facilities have put those procedures into operation. There are numerous examples of "accredited" jail facilities that are under court order for inadequate conditions of confinement. In addition, most of the national standards were developed as recommended procedures rather than regulations that measured *outcome*. Only recently has the term "performance-based" entered our vocabulary.

It must be noted, however, that management of jails and conditions of confinement have greatly improved since correctional standards were first promulgated in the early 1960s and the relationship between suicide prevention and national correctional standards has progressed significantly in recent years. Several national organizations and other influential bodies have recognized that,

because suicide remains the leading cause of death in jails, standards need to be promulgated and revised to address the specific area of suicide prevention. Once a footnote in medical care standards, suicide prevention is now addressed separately and distinctly in most national standards. Perhaps as best exemplified by the NCCHC standards, national guidelines for suicide prevention have provided the opportunity and framework for both large and small jail systems to create and build upon their policies and procedures for the prevention of suicides.

Reference Notes

[1]National Institute of Justice (1980), *American Prisons and Jails, Volume I, Summary Findings and Policy Implications of a National Survey,* Washington, D.C.: U.S. Department of Justice.

[2]See *Rhodes v. Chapman*, 452 U.S. 337 (1981).

[3]See *Bell v. Wolfish*, 441 U.S. 520 (1979).

[4]National Institute of Justice (1980), *American Prisons and Jails, Volume I, Summary Findings and Policy Implications of a National Survey,* Washington, D.C.: U.S. Department of Justice, p. 39.

[5]Rod Miller (1992), "Standards and the Courts: An Evolving Relationship," *Corrections Today,* 54 (3): 58-60.

[6]Ibid., p. 60.

[7]Utah Sheriff's Association (1995), *Utah Jail Standards*, Santa Clara, UT: Author.

[8]See, for example, the American Correctional Association (ACA)'s *Standards for Adult Local Detention Facilities* (1977, 1981, and 1991), the American Medical Association (AMA)'s *Standards for Health Services in Jails* (1977, 1989, 1979, and 1981), the American Psychiatric Association (APA)'s task force report and guidelines manual entitled *Psychiatric Services in Jails and Prisons* (1989, 2000), the American Public Health Association (APHA)'s *Standards for Health Services in Correctional Institutions* (1976 and 1986), the Commission on Accreditation for Law Enforcement Agencies (CALEA)'s *Standards for Law Enforcement Agencies* (1983, 1987, 1994, and 1999), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)'s *Ambulatory Health Care Standards Manual* (1990), the National Commission on Correctional Health Care (NCCHC)'s *Standards for Health Services in Jails* (1987, 1992, 1996, and 2003), and the U.S. Justice Department's *Federal Standards for Prisons and Jails* (1980).

[9]For example, both the CALEA and JCAHO standards lack any mention of suicide prevention protocols.

[10]See *Jail Suicide Update* (1989), 2 (2) and *Jail Suicide/Mental Health Update* (1996), 6 (4). In addition, both the AMA and APHA standards will not be reviewed here because they have not been revised in many years and for all practical purposes are no longer utilized. Although prisons and juvenile facilities are excluded from this review, both the ACA and NCCHC (as well as other organizations) have promulgated similar standards for these facilities.

[11]American Correctional Association (1981), *Standards for Adult Local Detention Facilities* (2nd Edition), College Park, MD: Author.

[12]American Correctional Association (1988), *Correctional Standards Supplement,* College Park, MD: Author.

[13]Ibid.

[14]American Correctional Association (1990), *Correctional Standards Supplement*, Laurel, MD: Author.

[15]American Correctional Association (1991), *Standards for Small Jail Facilities*, Laurel, MD: Author.

[16]American Correctional Association (1991), *Standards for Adult Local Detention Facilities* (3rd Edition), Laurel, MD: Author. Standard 2-5083 (Training) was renumbered as 3-ALDF-1D-12; standard 2-5273 (Screening) was renumbered as 3-ALDF-4E-19; standard 2-5274 (Health Appraisal) was renumbered as 3-ALDF-4E-21 and slightly revised and had the following addition: "A routine appraisal by mental health staff should be completed within 30 days of admission on all new inmates"; standard 2-5271 (Emergency Care) was renumbered as 3-ALDF-4E-24; and standard 2-5344 (Reception and Orientation) was renumbered as 3-ALDF-4A-01 and revised to include procedures for "suicide screening" upon admission.

[17]Special management inmate was defined as "an individual who presents a serious threat to the safety and security of the facility, staff, general population, or himself/herself."

[18]American Correctional Association (2004), *Performance-Based Standards for Adult Local Detention Facilities* (4th Edition), Lanham, MD: Author

[19]Commission on Accreditation for Law Enforcement Agencies (1994), *Standards for Law Enforcement Agencies*, Fairfax, VA: Author.

[20]Curiously, the 1983 edition of the CALEA standards required that "arrestees should be under observation *at all times* by facility staff." In addition, arrestees were required to be "*personally observed* by facility staff." The phrase "at all times" was removed from the 1987 edition, and "personally observed" was replaced by "visually observed," presumably in order to allow holding facilities to use closed circuit television monitoring.

[21]Commission on Accreditation for Law Enforcement Agencies (2004), *Standards for Law Enforcement Agencies*, Fairfax, VA: Author.

[22]National Commission on Correctional Health Care (1987), *Standards for Health Services in Jails*, Chicago, IL: Author.

[23]National Commission on Correctional Health Care (1992), *Standards for Health Services in Jails* (2nd Edition), Chicago, IL: Author. In addition, J-31: Receiving Screening remained intact, J-34 was renumbered as J-36: Mental Health Evaluation, and CPR training was incorporated into J-22: Continuing Education for Qualified Health Services Personnel and J-23: Training for Correctional Officers. Further, J-09: Procedure in the Event of an Inmate Death was created to require a mortality review following fatalities.

[24]Ibid., pp. 157-158.

[25]National Commission on Correctional Health Care (1996), *Standards for Health Services in Jails* (3rd Edition), Chicago, IL: Author. In addition, J-09 was renumbered as J-10: Procedure in the Event of an Inmate Death, J-22 was renumbered as J-18: Continuing Education for Qualified Health Services Personnel, J-23 was renumbered as J-19: Training for Correctional Officers, J-31 was renumbered as J-30: Receiving Screening, and J-36 was renumbered as J-39: Mental Health Evaluation.

[26]Ibid., pp. 99 and 149.

[27]National Commission on Correctional Health Care (2003), *Standards for Health Services in Jails* (4th Edition), Chicago, IL: Author.

[28]National Commission on Correctional Health Care (2003), *Correctional Mental Health Care: Standards and Guidelines for Delivering Services* (2nd Edition), Chicago, IL: Author

[29] American Psychiatric Association (1989), *Task Force Report 29: Psychiatric Services in Jails and Prisons*, Washington, DC: Author.

[30] American Psychiatric Association (2000), *Psychiatric Services in Jails and Prisons*, Washington, DC: Author.

[31] Anno, B.J. (1991), *Prison Health Care: Guidelines for the Management of an Adequate Delivery System*, Washington, DC: National Institute of Corrections, U.S. Department of Justice, p. 18. ❑

STATE JAIL STANDARDS AND SUICIDE PREVENTION: A REPORT CARD

In 1996, the ***Update*** surveyed all 50 states in an effort to determine the general extent of jail standards within those jurisdictions, as well as critique the degree to which state standards reflected provisions of suicide prevention.[1] That survey showed that only 32 of 50 states had either mandatory or voluntary standards, a significant drop from an earlier survey of 36 jail standards in 1989.[2] Of those states with jail standards in 1996, most lacked the basic criteria for suicide prevention. For example, only 11 state standards required suicide prevention policies, only 14 state standards required suicide risk inquiry in screening forms, only 11 state standards specified suicide prevention training in staff training curricula, and only 4 state standards required constant observation of high risk suicidal inmates.

As a follow-up to the earlier survey, the ***Update*** recently surveyed all 50 states in an effort to once again determine the degree to which state jail standards address the issue of suicide prevention. The survey found that 29 states currently have jail standards, with 18 mandatory and 6 voluntary programs.[3] Six states (Alaska, Connecticut, Delaware, Hawaii, Vermont and Rhode Island) operate integrated jail and prison systems and, therefore, have not promulgated jail standards. One state (West Virginia) operates a regional jail system. The remaining 14 states —Arizona, Colorado, Georgia, Kansas, Louisiana, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, South Dakota, Washington, and Wyoming — have no jail standards. Since the ***Update's*** 1996 survey, three states (Kansas, Montana, and New Hampshire) dropped their jail standards, while two states (Florida and Oregon) adopted jail standards.

The survey found that jail standards were typically administered by the state departments of correction, although a handful of states utilized other oversight agencies (state boards or commissions) or private entities (e.g., state sheriffs' association). To measure compliance, 70 percent of the state standards required annual inspections. In regard to the areas of enforcement and investigation, while 61 percent of the state standards permitted the agencies to have enforcement authority, only 39 percent were required to be notified by jail officials in the event of an inmate suicide, and only 35 percent permitted the agencies to conduct on-site reviews and/or investigations of inmate suicides. Finally, jail standards applied to both county and local facilities in 18 states, and only to county jails in 11 states.

In order to measure the comprehensiveness of suicide prevention provisions contained within state jail standards, both ACA Standard 3-ALDF-4E-34 (1991) and NCCHC Standard J-G-05 (2003) were utilized as yardsticks. For this analysis, the ***Update*** combined the requirements of both standards and identified the six (6) most critical components to a suicide prevention policy: staff training, intake screening/assessment, housing, levels of supervision, intervention, and mortality review. As detailed in the table on page 9, *the survey found that most state jail standards continue to lack the basic criteria for suicide prevention. Only 41 percent (12 of 29) of all state standards required jail facilities to maintain suicide prevention policies, a slight increase from the 1996 survey.*

Of the 12 states with jail standards requiring a suicide prevention policy, only two – Ohio and Texas — contained a provision for addressing all six critical suicide prevention components. Jail standards in California, Iowa, Massachusetts and South Carolina required that suicide prevention policies contain five components; while standards in Illinois, Minnesota, New Jersey, and Wisconsin required policies addressing three components, and suicide prevention policies in both the Pennsylvania and Virginia jail standards addressed two components. Thus, *only six states had jail standards that required policies addressing all or all but one critical component in suicide prevention.*

Staff Training

The survey found that *only 45 percent of state jail standards required that facility staff receive suicide prevention training*. This finding was an increase from the 1996 survey where only 34 percent of jail standards required staff training in suicide prevention. The current survey also found that *only four state standards (14%) required both pre-service and annual suicide prevention training.* The training requirements of the Illinois jail standards perhaps best exemplified the importance of this protocol:

> "Annually, mental health professionals shall provide training to all jail officers and other personnel primarily assigned to correctional duties on suicide prevention and mental health needs. Suicide prevention training shall include the nature and symptoms of suicide; the specifics of identification of suicidal individuals through the recognition of verbal and behavioral cues, situational stressors, evaluation of detainee coping skills, and other signs of potential risk; monitoring; evaluation; stabilization; and referral of suicidal individuals."[4]

Intake Screening/Assessment

The survey found that *72% of state jail standards required suicide risk inquiry during the intake screening process*. This finding was an increase from the 1996 survey where only 44 percent of the standards addressed the issue of screening for suicide risk. The language from the Utah jail standards provided an example of this protocol's importance:

> "Before accepting custody of a prisoner, the jail officer should reasonably ensure that the transporting officer has provided all information known to him (including risk of attempting suicide) which would be relevant to and necessary to safely and securely handle and house the prisoners....Suicide risk screening is done as a pro-active

SUICDE PREVENTION PROTOCOLS WITHIN STATE JAIL STANDARDS

State	Applicable Facility	Prevention Policy	Training (pre/annual)	Screening/ Assessment	Housing	Suicide Watch Levels (in minutes)	Intervention	Mortality Review	Last Revision
Alabama	1					not specified			1982
Arkansas	2				x	30	(CPR)		1987
California	2	x	x	x	x	15		x	2004
Florida	2				x	"not to exceed 15 minutes"			2004
Idaho	1			x		"more frequent" (than 30)			2003
Illinois	1	x	x/x	x		"more frequent" (than 30)	(CPR)		2004
Indiana	1				x	"consistent with behavior"	(CPR)		1996
Iowa	2	x	x	x	x	30	x		2001
Kentucky	1					20	(CPR)		2002
Maine	2		x/x	x	x	"continuous" and 15	x (CPR)		1992
Maryland	2			x		30	x (CPR)		1995
Massachusetts	1	x	x	x		"continuing"	x (CPR)	x	1999
Michigan	1			x		not specified			1998
Minnesota	2	x	x	x		"more frequent" (than 30)	(CPR)		1999
Nebraska	2		x			not specified	(CPR)		1994
New Jersey	2	x	x	x		not specified	x (CPR)		2004
New York	2			x	x	"constant: continuous"	(CPR)	x	2001
North Carolina	2				x	15			1993
North Dakota	1		x	x		10	x (CPR)		2002
Ohio	2	x	x/x	x	x	10	x		2003
Oklahoma	2			x		"observed frequently"	(CPR)		2003
Oregon	1			x		not specified	(CPR)		2004
Pennsylvania	1	x	x	x		not specified			2001
South Carolina	2	x	x/x	x	x	"short, irregular intervals"	x		1994
Tennessee	2					"more frequent" (than 60)			2004
Texas	1	x	x	x	x	30	x	x	2004
Utah	1			x		not specified			1998
Virginia	2	x		x	x	not specified	(CPR)		2002
Wisconsin	2	x		x	x	not specified	x		1999

Code: 1=County only; 2=County and Local

means of attempting to prevent prisoner suicides by: a) identifying risk factors which indicate a potential for suicidal behavior; b) evaluating observations and available information to assess risk levels; and c) initiating appropriate preventative procedures based on the evaluation of risks."[5]

Housing

The survey found that *only 45 percent of state jail standards required provisions for staff housing potentially suicidal inmates*. Most of the standards that addressed housing concentrated on issues of cell location, inmate clothing and use of restraints; few addressed the removal of obvious protrusions within cells that were conducive to hanging attempts. There were, however, two notable exceptions. The North Carolina jail standards stated that:

> "...Doors, locks, detention hardware and bunks shall be designed to inhibit their use for an attempted suicide...In each jail the safety equipment, including intercoms, fire extinguishers, smoke detectors, and sprinkler heads, shall be tamper-resistant...The ducts for the (mechanical) systems shall be designed to...inhibit their use for attempted suicide...Clothing or towel hooks shall not be used."[6]

In California, guidelines addressed "suicide hazards" by stating that "the facility design shall avoid any surfaces, edges, fixtures, or fittings that can provide an attachment for self-inflicted injury….

(a) plumbing shall not be exposed. Operation of control values shall use flush buttons or similar. The drinking fountain bubbler shall be without curved projections;

(b) towel holders shall be ball-in-socket or indented clasp, not pull-down hooks or bars;

(c) supply and return grilles shall have openings no greater than 3/16 inch or have 16-mesh per square inch;

(d) beds, desk surfaces, and shelves shall have no sharp edges and be configured to prevent attachment;

(e) light fixtures shall be tamper resistant;

(f) fixtures such as mirrors shall be mounted using tamper resistant fasteners; and

(g) fire sprinkler heads inside rooms shall be designed to prevent attachment."[7]

Levels of Supervision

The survey found that *although 69 percent of the state standards addressed the component of supervising suicidal inmates, only 7 percent (or two)required provisions for "continuous" or "constant" observation as the highest level of supervision for potentially suicidal inmates.* An additional 17 percent of jail standards required observation of either 10 or 15-minute intervals as the highest supervision level; 21 percent required observation at 20-minute or "more frequent than" 30-minute intervals; and 14 percent at 30-minute intervals. The remaining state standards (10%) utilized vague language (e.g., requiring observation that was "consistent with that behavior," "observed frequently," etc.) to describe supervision levels. The New York jail standards contained the most concise definition of *constant supervision*:

> "...the uninterrupted personal visual observation of prisoners by facility staff responsible for the care and custody of such prisoners without the aid of any electrical or mechanical surveillance devices. Facility staff shall provide continuous and direct supervision by permanently occupying an established post in close proximity to the prisoners under supervision which shall provide staff with: (1) a continuous clear view of all prisoners under supervision, and (2) the ability to immediately and directly intervene in response to situations or behavior observed which threaten the health or safety of prisoners or the good order of the facility."[8]

Intervention

The survey found that *only 34 percent of state jail standards required provisions for intervention following the discovery of a suicide attempt*. In addition, 55 percent of the standards required CPR and first aid training of at least one correctional officer per shift. This protocol was best exemplified by the Maine jail standards which required, in part, that "all certified correctional officers shall receive and maintain certification in adult cardiopulmonary resuscitation...facility medical staff shall determine strategic locations for first-aid kits and determine their contents. Medical staff shall establish a procedure to inspect first-aid kits at least quarterly. First aid kits shall be kept complete at all times."[9] In the event of a suicide attempt, the Maine standards also required specific procedures for the following: "responsibilities of the discovering officer, emergency medical treatment, required notification and documentation, and debriefing."

Mortality Review

The survey found that *only five (17%) state jail standards required provisions for an administrative or mortality review following an inmate suicide*. The Ohio jail standards described the process as follows: "The (suicide prevention) plan specifies procedures for medical and administrative review if a suicide or serious suicide attempt, as defined in the suicide plan, occurs."[10]

Conclusion

Similar to findings from both the 1989 and 1996 surveys, the report card from the current 29 state jail standards again indicated failing grades for suicide prevention. With a few notable exceptions, most state standards continue to fail to follow the suicide prevention guidelines as promulgated by either the American Correctional Association or National Commission on Correctional Heath Care.

UPDATE
ON THE INTERNET

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

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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

References

[1]See *Jail Suicide/Mental Health Update* (1996), 6 (4): 6-8.
[2]See *Jail Suicide Update* (1989), 2 (2): 4-5.
[3]The type of standards in five states was unknown because those jurisdictions failed to participate in the survey.
[4]Joint Committee on Administrative Rules (2004), "Title 20: Corrections, Criminal Justice and Law Enforcement, Chapter I: Department of Corrections, Subchapter f: County Standards, Part 701 County Jail Standards," *Administrative Code*, Springfield, IL: Illinois General Assembly.
[5]Utah Sheriff's Association (1998), *Utah Jail Standards*, Santa Clara, UT: Author.
[6]North Carolina Department of Human Resources, Division of Facility Services (1993), *Rules and Laws Governing the Operations, Surveillance and Monitoring of Jail Facilities (10 NCAC 3J)*, Raleigh, NC: Author.
[7]California Board of Corrections (2001), "Physical Plant Guidelines, Minimum Standards for Local Detention Facilities, Title 24, Parts 1 and 2," *California Code of Regulations*, Sacramento, CA: Author, p. 17.
[8]New York State Commission of Correction (2001), *Subtitle AA, Chapter I: Minimum Standards and Regulations for Management of County Jails and Penitentiaries*, Section 7003.2, Albany, NY: Author.
[9]Maine Department of Corrections, (1992), *Detention and Correctional Standards for Counties and Municipalities*, Augusta, ME: Author.
[10]Bureau of Adult Detention (2003), *Minimum Standards for Jails in Ohio, Full Service and Minimum Security Jails*, Columbus, OH: Department of Rehabilitation and Corrections, p.30. ❑

Wever v. Lincoln County: Can Prior Suicides in Jail Exemplify Deliberate Indifference?

On December 8, 2001, Dennis Wever committed suicide in the Lincoln County Jail in North Platte, Nebraska, despite the fact he had threatened suicide to both arresting officers and jail personnel. His family subsequently filed a federal lawsuit against Lincoln County, its sheriff, the North Platte Police Department, its chief of police, and several officers alleging that their deliberate indifference was the proximate cause of Mr. Wever's death. The complaint also alleged that the sheriff failed to take any corrective action in the areas of training and supervision of personnel following two other prior inmate suicides in the jail. On November 4, 2004, the U.S. Court of Appeals for the Eighth Circuit ruled that the sheriff was not entitled to qualified immunity. The decision in ***Wever v. Lincoln County*** *(No. 03-3633, 2004 U.S. App. Lexis 22974, 8th Cir. 2004) is reprinted below.*

Before MORRIS, SHEPPARD, ARNOLD, MAGILL, and MURPHY, Circuit Judges.

MAGILL, Circuit Judge.

This case arises from the following tragic facts. On December 8, 2001, Lincoln County officers responded to a 911 call from an emotionally despondent Dennis Wever. Though Wever threatened to kill himself if jailed, the officers arrested Wever, brought him to jail, placed him in an isolation cell, and gave him a blanket upon his request. Less than half an hour after making the threat,Wever hung himself with the blanket. He was the third person in five years to commit suicide in the Lincoln County jail.

Wever's mother, acting as his personal representative, brought a § 1983 claim against James Carmen, the sheriff of Lincoln County, and various officers, alleging that his deficient training and supervision of the officers involved in the arrest and incarceration deprived her son of rights under the Fourteenth Amendment. Carmen moved for summary judgment based on qualified immunity and for dismissal for failure to state a claim. The district court denied the motion, holding that the complaint stated a violation of the Fourteenth Amendment and that Carmen had not established he was due qualified immunity. We have jurisdiction to review the district court's denial of qualified immunity pursuant to 28 U.S.C. § 1291, and we affirm. As we discuss below, we lack jurisdiction to review the district court's determination that Wever's complaint states a claim.

Wever called 911 on December 8, 2001 at approximately 3:30 pm. The 911 call log reveals he was depressed and crying. A number of Lincoln County police officers were dispatched to the home of Wever's father. Upon their arrival, Wever emerged from the home and engaged in a discussion with the officers. The officers were concerned that he was suicidal because of the 911 call and his demeanor upon their arrival. During this discussion, Wever's father returned home and attempted to aid the officers in calming Wever. Various officers' reports reflect that several times during the initial discussion, Wever stated that he was not going to kill himself. Wever eventually consented to go to a hospital and speak with a doctor. However, for reasons not made clear by the various officers' reports and Carmen's brief, the officers decided instead to arrest him. Carmen alleges only that Wever was arrested "because of his combative and volatile state." Br. of Defendant-Appellant at 8.[1] One of the officers in charge during the arrest, Sergeant Tolle, was similarly vague as to the justification for the arrest, suggesting little more than that Wever was arrested for speech the officers found offensive: "Due to Dennis's yelling obscenities and derogatory remarks and his lack of cooperation and the feeling that without taking action of some sort the problem would only continue I also felt that Dennis needed to be taken into custody." J.A. at 57-58.[2]

Wever offered to go with the police peacefully on the condition that he not be handcuffed. The officers refused, and instead wrestled Wever to the ground and forcibly handcuffed him. During this process, Wever suffered an abrasion to his left cheek. Over the course of the confrontation, he yelled obscenities and threatened the officers. Upon being arrested and placed in a squad car, Wever kicked out the back window. He was then removed from the car, thrown to the ground, physically subdued, and put in leg chains. Wever's mother alleges that after they had subdued him, the officers continued to beat and kick him while he was on the ground.[3] Officers then placed Wever in another car and took him to a hospital. After being advised of his combative behavior, the responding nurse opted to treat Wever in the squad car. She opined that the injury to his face was merely a scratch and signed a Medical Clearance Report, checking a box accompanied by the following typed, pre-printed text: "I have examined the prisoner and find him/her acceptable for admission to the jail. I have no specific suggestions regarding care of this prisoner *for the condition for which I have examined him/her*." J.A. at 28 (emphasis added). Carmen does not assert that the treating nurse was advised of suicidal threats Wever made at the hospital. More importantly, the record indicates the medical clearance the nurse gave Wever was specifically for the scratch on his cheek.

Until the time he was arrested, Wever told the officers that though he was depressed, he did not intend to kill himself.[4] However, once the officers decided to arrest him, Wever made it clear that he would kill himself if jailed. While waiting in the car at the hospital, Wever stated several times that he would hang or otherwise kill himself if he was taken to jail. According to officer Dowhower, who drove the car, Wever was emphatic in stating that he would kill himself if jailed. Nevertheless, after Wever's cut was examined, Dowhower took Wever to the county jail, where the jailer was advised of Wever's threats. When Wever arrived at the jail, he "made a comment to the [e]ffect of 'now it's time.'" J.A. at 54.

Despite the fact that he had repeatedly threatened suicide, Wever was placed in an isolation unit at about 5:00 pm. He asked to make a call at approximately 5:08, and was allowed to do so. He was unable to reach the party and asked officer Klingsporn if he could try later. Klingsporn agreed, and returned Wever to the isolation cell, whereupon Wever requested a blanket. Though Klingsporn had been advised by one of the arresting officers only minutes earlier that Wever had threatened suicide, he brought Wever a blanket at approximately 5:14. In a report written after the incident, Klingsporn stated: "I asked him if he promised not to do anything

with it except cover himself up. He said he wasn't going to do anything with the blanket. He also joked about there not being anywhere in Iso to hang himself…." J.A. at 61. At approximately 5:30, officer Wilson went to check on Wever and discovered him hanging in his cell by the blanket Klingsporn had provided. Wever had been in the county jail only half an hour after threatening suicide. He was brought to a hospital and pronounced dead.

It is undisputed that Sheriff Carmen took no personal part in the arrest, nor was he present at the jail during the suicide.

Wever's representative sued Carmen in his individual capacity for deliberate indifference to Wever's serious medical needs as a pretrial detainee known to be suicidal. Carmen filed a motion for summary judgment accompanied by only two exhibits spanning a mere three pages: a two-page affidavit signed by Carmen, and a one-page medical form signed by the nurse who examined Wever. His summary judgment motion argued that Wever failed to state a claim and that Carmen was due qualified immunity for the sole reason that he had no personal involvement in the arrest. Absent from Carmen's affidavit is mention of any training given to Lincoln County officers concerning treatment of suicidal inmates; nor does it relate any policy for dealing with suicidal inmates, or when any such policy was implemented. Finally, it omits two prior suicides which occurred at the jail and what, if any, preventive steps may have been taken following those suicides. Carmen's motion and accompanying brief similarly omitted any discussion of liability he may have as a supervisor for inadequate training or supervision of the numerous Lincoln County officers who interacted with Wever shortly before his death.

The district court denied Carmen's meagerly supported motion, construing the complaint to adequately allege a Fourteenth Amendment violation by Carmen, and holding that Carmen was not due summary judgment in large part because he "did not present any evidence showing what training procedures, if any, were in place for handling potentially suicidal detainees or inmates, nor did he present any evidence showing what steps, if any, were taken following" an earlier suicide that had occurred during his tenure as sheriff. *Wever v. Lincoln County, Neb.*, No.7:02CV05016, 5 (D. Neb. Sept. 24, 2003). Carmen appeals. We affirm the district court.

We review a denial of a summary judgment motion claiming qualified immunity de novo, considering it only to the extent it turns on an issue of law. *Bankhead v. Knickrehm*, 360 F.3d 839, 842-43 (8th Cir. 2004). In order to determine whether Carmen is due qualified immunity, "we must perform two inquiries in 'proper sequence.'" *Coleman v. Parkman*, 349 F.3d 534, 537 (8th Cir. 2003) (citation omitted). First, we "must ask whether, when viewed in the light most favorable to the plaintiff, the alleged facts show the official's conduct violates a constitutional right." *Id*. at 538. If the answer to this question is "yes," then we ask a second question: '"whether the right was clearly established.'" *Id.* (quoting *Saucier v. Katz*, 533 U.S. 194, 201 (2001)). Only the first inquiry is at issue in this case. As a pretrial detainee, Wever had a clearly established Fourteenth Amendment right to be protected from the known risks of suicide.[5] *Yellow Horse v. Pennington County*, 225 F.3d 923, 927 (8th Cir. 2000).[6]

As the party moving for summary judgment based on qualified immunity, Carmen bears the burden of demonstrating that "no material issues of fact remain as to whether [his] actions were objectively reasonable in light of the law and the information [he] possessed at the time of his actions." *Cross v. Des Moines*, 965 F.2d 629, 632 (8th Cir. 1992).

In his motion for summary judgment, Carmen argued only that he was due qualified immunity as a matter of law because he had no personal involvement in Wever's arrest. Wever's brief in opposition and Carmen's reply brief, however, addressed supervisory liability. Despite the fact that Carmen did not initially raise any issues of supervisory liability, the district court considered Carmen's liability as a supervisor and held that he was not entitled to qualified immunity as a matter of law.

As for the issue raised by Carmen, it is plain that he cannot be held liable on a theory of respondeat superior for any constitutional violations committed by the officers who arrested and jailed Wever. *Boyd v. Knox*, 47 F.3d 966, 968 (8th Cir. 1995). However, this does not mean that Carmen, to be held liable, must have personally participated in any constitutional deprivation committed by his officers, or must have known about any violation at the time it occurred. *Howard v. Adkison*, 887 F.2d 134, 138 (8th Cir. 1989) ("Proof of actual knowledge of constitutional violations is not, however, an absolute prerequisite for imposing supervisory liability."). To the extent Carmen suggests otherwise in his motion to dismiss and his brief before this court, he is in error. Rather, a supervisor

> may be held individually liable under § 1983…if a failure to properly supervise and train the offending employee caused a deprivation of constitutional rights. The plaintiff must demonstrate that the supervisor was deliberately indifferent to or tacitly authorized the offending acts. This requires a showing that the supervisor had notice that the training procedures and supervision were inadequate and likely to result in a constitutional violation. *Andrews v. Fowler*, 98 F.3d 1069, 1078 (8th Cir. 1996) (internal citations omitted).

Though Carmen did not contest supervisory liability in his motion for summary judgment, Wever's brief opposing summary judgment raised the issue and Carmen addressed it in his reply brief. Carmen did not, however, include any materials outside the pleadings regarding supervisory liability. The district court considered whether, taking the facts as alleged by Wever, Carmen was immune from supervisory liability as a matter of law. Because Carmen failed to adduce any evidence regarding supervisory liability, and put forward his motion before any significant discovery had been undertaken, we will not penalize Wever for possible deficiencies in evidence.[7] See *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986) (requiring "adequate time for discovery"); see also *Iverson v. Johnson Gas Appliance Co.*, 172 F.3d 524,530 (8th Cir.1999). Instead, just as the district court, we will only consider whether, taking Wever's allegations as true, Carmen should be granted qualified immunity as a matter of law. *N. Ark. Med. Ctr. v. Barrett*, 962 F.2d 780, 784 (8th Cir. 1992) (recognizing that a summary judgment motion based on the pleadings is the "functional equivalent" of a motion to dismiss). Carmen raises two arguments against supervisor liability in his brief before this court: First, he disputes that he had the requisite notice that his training procedures and supervision were inadequate; and second, he argues that he had a constitutionally sufficient policy in place.

Wever's complaint alleges that Carmen was aware of two prior suicides in the Lincoln County jail, one occurring in 1999 while he was sheriff, and one occurring in 1996, prior to his tenure.[8] Carmen argues that as a matter of law, one or two suicides are insufficient to put a sheriff on notice that his training and supervision is constitutionally inadequate. Under his proposed rule, a sheriff may sit idly by until at least a third inmate known to be suicidal takes a blanket from an officer and hangs himself, only then ordering his officers not to place a suicidal person in an isolation cell and hand him a blanket. We decline to so hold.

We have previously stated that, in most circumstances, a single incident does not provide a supervisor with notice of deficient training or supervision: "[A] single incident, or a series of isolated incidents, usually provides an insufficient basis upon which to assign supervisory liability." *Howard v. Adkison*, 887 F.2d 134, 138 (8th Cir. 1989) (emphasis added). However, as indicated, this calculus is not rigid, and must change depending on the seriousness of the incident and its likelihood of discovery. In *Howard*, the alleged constitutional violation was caused by an unsanitary cell. *Id*. at 136. A supervisor is not expected to be put on notice of constitutionally deficient sanitation training by a single instance of a dirty cell. But we cannot equate death with dirty cells. Our case law reflects this flexible calculus. In *Andrews*, the plaintiff sued a police chief for failing to supervise an officer who ultimately raped two women. 98 F.3d at 1073-74. We held that the chief's knowledge of two prior complaints against the officer for making inappropriate sexual advances to women during traffic stops was sufficient to create an issue of material fact as to notice, rendering summary judgment improper. *Id*. at 1078. In some circumstances, one or two suicides may be sufficient to put a sheriff on notice that his suicide prevention training needs revision. In the present case, Wever has alleged that Carmen was placed on notice by two previous suicides, and we cannot say this is insufficient as a matter of law.

In the alternative, Carmen asserts that "the jail had a good-faith policy in place for dealing with those prisoners and pretrial detainees presenting suicidal risks. Furthermore, after the September 1999 incident, the policy was implemented for approximately two (2) years before the incident at issue occurred." Br. of Defendant-Appellant at 24 (internal citation omitted). The implication of this statement is that after the 1999 suicide, Carmen implemented a constitutionally adequate suicide policy that was in effect at the time of Wever's suicide. However, this argument is not properly before us. Carmen did not raise it before the district court, and unlike the notice issue, the district court did not delve into it. Ordinarily, this court will not consider arguments raised for the first time on appeal. *Orr v. Wal-Mart Stores, Inc*., 297 F.3d 720, 725 (8th Cir. 2002). Nor do the recognized exceptions apply here. *Id*. ("We consider a newly raised argument only if it is purely legal and requires no additional factual development, or if a manifest injustice would otherwise result."). Moreover, we note that the quoted assertion is entirely without support in the record. The "policy" Carmen cites is a single page offered by Wever, and wholly without context. One cannot tell when, how, or even whether it was adopted, why Carmen believed it would adequately respond to the problem of inmate suicide,[9] or how officers were trained to implement it. His assertion that the "policy" was implemented after the 1999 suicide is also unsubstantiated.[10] One cannot discern when the "policy" was adopted, and Carmen neglected to make any mention of it in his affidavit in support of his motion for summary judgment. As the district court stated, "Sheriff Carmen did not present any evidence showing what training procedures, if any, were in place for handling potentially suicidal detainees or inmates." *Wever v. Lincoln County*, Neb., No. 7:02CV05016, 5 (D. Neb. Sept. 24, 2003).[11]

We affirm the decision of the district court denying Carmen qualified immunity.

References

[1]Carmen does not state which Nebraska law this violates.

[2]The arrest form indicates that Wever was arrested for criminal mischief, resisting arrest, and disturbing the peace. J.A. at 66. The first two alleged crimes occurred only after the officers decided to arrest Wever—he resisted their attempt to handcuff him and kicked out the window of the police cruiser. Thus, they cannot possibly be the reason for the arrest. It is unclear whether the allegation of disturbing the peace refers to Wever yelling obscenities at the throng of police officers gathering in his father's yard, or the scuffle that ensued when the officers decided to handcuff him. Regardless, reading the record in the light most favorable to Wever, the decision to arrest him was rather thinly supported.

[3]Carmen disputes this allegation.

[4]The 911 call log states that previous to his arrest, Wever told the dispatcher that he was not suicidal. This is supported by the reports of officers Foote and Toelle.

[5]Carmen contends on appeal that the district court erred in interpreting Wever's complaint. Essentially, Carmen argues that the district court erred in interpreting Wever's broadly worded complaint to "adequately set forth a Fourteenth Amendment claim against Sheriff Carmen for failure to provide Wever, a pretrial detainee, mental health care." *Wever*, No.7:02CV05016 at 2. Though neither party has so argued, we lack jurisdiction to review the district court's interlocutory interpretation of Wever's complaint. This court has jurisdiction over "final decisions" of district courts. 28 U.S.C. §1291. The district court's decision denying Carmen's motion based on the sufficiency of the pleadings is not final—the claim goes forward. This court does have jurisdiction to hear interlocutory appeals from the denial of summary judgment based on qualified immunity. *Beck v. Wilson*, 377 F.3d 884, 888-89 (8th Cir. 2004). Jurisdiction based on the denial of qualified immunity does not extend to matters that are not "final" unless the two are inextricably intertwined. See *Kincade v. City of Blue Springs*, 64 F.3d 389, 394-95 (8th Cir. 1995). The district court's construction of the complaint to adequately allege a claim is not inextricably intertwined with the district court's ruling on qualified immunity. See *Hafley v. Lohman*, 90 F.3d 264, 266 (8th Cir. 1996). We therefore lack jurisdiction to review the district court's construction of the complaint. Because we cannot review the district court's decision, we use its conclusion that Wever adequately set forth a complaint for failure to provide mental health care to a pretrial detainee in our qualified immunity analysis.

[6]While *Yellow Horse* involved an Eighth Amendment claim, it is well established that pretrial detainees such as Wever are "accorded the due process protections of the Fourteenth Amendment, protections 'at least as great' as those the Eighth Amendment affords a convicted prisoner." *Boswell v. Sherburne County*, 849

F.2d 1117, 1121 (8th Cir. 1988). We have previously suggested that the burden of showing a constitutional violation is lighter for a pretrial detainee under the Fourteenth Amendment than for a post-conviction prisoner under the Eighth Amendment. *Smith v. Copeland*, 87 F.3d 265, 268 n.4 (8th Cir. 1996).

[7]The motion was timed before the completion of discovery, and it argued that the plaintiff failed to state a claim and that, taking the allegations in the complaint as true, the defendant was due qualified immunity as a matter of law. Dist. Ct. Docket Entry 45 (staying discovery until resolution of another defendant's motion for summary judgment).

[8]Though Carmen was not sheriff during the 1996 suicide, Wever's complaint alleges that Carmen was aware of both suicides. Carmen does not deny he was aware of the 1996 suicide.

[9]The alleged policy states:

> For Self-Protection of Inmate. When an inmate's behavior indicates he may injure himself, he will be placed in an isolation cell.
> a. Restraints. If the inmate's behavior continues directed toward self destructive behavior, the inmate will be placed in restraints….
> b. Observation. The jailer shall observe the inmate on a frequent basis, AT LEAST EVERY FIFTEEN (15) MINUTES….
> c. Reporting. The jailer will report the placement of an inmate in isolation and the use of restraints to the Jail Supervisor immediately. The jailer will complete a Record of Restraint Form and prepare an Incident and Discipline Report Form.

J.A. at 68. We note this "policy" would not have prevented the instant suicide, which was not at all unexpected—Wever did exactly what he promised to do shortly after swearing he would do it. The policy does not advise officers against giving suicidal prisoners sheets, blankets, or even ropes should they ask. Moreover, Wever has offered evidence tending to show that placement in isolation cells is overwhelmingly disfavored as a means of monitoring and treating suicidal prisoners. Carmen has not responded to this argument.

[10]Carmen cites an answer to an interrogatory in which he gave no information about the two suicides other than the names of the inmates and the dates on which they occurred. No policy is mentioned. J.A. at 60.

[11]The fact that the district court considered no policy and held that Carmen had not offered evidence of training serves to strip us of jurisdiction over the issue. Because of the deficiency of evidence, the district court came to no legal conclusion about the adequacy of any training. Our jurisdiction over this appeal extends only to "purely legal determinations made by the district court." *Wilson*, 260 F.3d at 951. We therefore express no view as to the sufficiency of any evidence that Carmen may be able to present the district court regarding actual notice and adequacy of training in a later motion for summary judgment. See, e.g., *Whitford v. Boglino*, 63 F.3d 527, 530 (7th Cir. 1995) ("Denial of summary judgment….does not establish res judicata."). ❑

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.

Pennsylvania

In November 2004, the City of Philadelphia agreed to pay $3.5 million to the guardian of a man who suffered irreversible brain damage after trying to hang himself inside a holding cell at the Philadelphia Police Department headquarters five years earlier.

Christopher Foster was arrested on July 30, 1999 and charged with blocking vehicle traffic on a city street. After threatening suicide to a police officer, Mr. Foster was transported to a district police department lockup facility and placed on suicide precautions. But when transferred to the main holding facility at the Police Administration Building, officers there were not informed that he was suicidal. Mr. Foster was placed in a standard holding cell without any suicide precautions to await a bail hearing. A short time later, he was discovered hanging from the cell door by his shirt. Although emergency medical treatment was provided, Mr. Foster suffered irreversible brain damage and remains totally incapacitated.

"Mr. Foster's vulnerability to suicide was patently obvious, yet recklessly ignored," plaintiff attorneys Jonathan M. Cohen and Dominic Guerrini wrote in a pretrial memorandum. "Moreover, the city's reckless and deliberate indifference to training in suicide screening, which would have prevented Mr. Foster's injury, constitutes a separate constitutional violation," the lawyers asserted.

The city offered to settle the case only after a weeklong trial and closing arguments. Mr. Foster's guardian, who had sought damages in the range of $9.3 million to nearly $50 million to cover estimated costs of caring for him over his 20-year life expectancy, agreed to accept the much lower $3.5 million to bring the case to a close. "She wanted... finality at this point," Attorney Cohen told the *Philadelphia Daily News*. "He's in a nursing home. Hopefully, he'll be able to come home" to be with his mother.

Mississippi

In what the American Civil Liberties Union (ACLU) has called the most comprehensive decision regarding death row conditions in the last 10 years, the U.S. Court of Appeals for the 5th Circuit has affirmed a lower court's opinion that the state's death row unit at Mississippi State Penitentiary in Parchman is unconstitutional and requires corrective action.

In a ruling issued on June 28, 2004, the appeals court ordered state prison officials in *Russell v. Johnson* (No. 03-60529) to fix malfunctioning toilets that spill human waste into cells, provide

fans and ice to prisoners on exceedingly hot days, stop mosquito infestations, and properly treat prisoners suffering from mental illness. "We believe this decision will have far-reaching implications for thousands of other prisoners," said Margaret Winter, Associate Director of the ACLU's National Prison Project. "We know that brutal prison conditions have existed on Mississippi's death row for many years. The appeals court has now affirmed that while the state may be authorized to execute death-sentenced prisoners, it may not torture prisoners to death while they are pursuing their rights to appeal their sentences."

The ACLU brought the challenge to the death row conditions together with the Holland and Knight law firm, which provided pro bono assistance in the case. "Official indifference has brought the men on death row to the brink of physical and mental breakdown," said Steve Hanlon, a partner at Holland and Knight. "We applaud the court's decision for the human rights protections it affords to prisoners."

At issue in the June 28 ruling was an appeal filed by the Mississippi Department of Corrections (MDOC) to stop a federal district court order that found officials had violated "minimal standards of decency, health and well-being" because of the deplorable conditions on death row. The state was required to remedy those conditions under the district court's order. In March 2003, U.S. Magistrate Judge Jerry A. Davis had ruled that "no matter how heinous the crime committed, there is no excuse for such living conditions" on death row.

Commenting on the trial court's findings, the 5th Circuit panel wrote:

> "The ninth injunction outlines a number of requirements designed to alleviate some of the problems stemming from the allegedly inadequate mental health care afforded the inmates on Death Row. This injunction requires MDOC to comply with American Correctional Association (ACA) and National Commission on Correctional Health Care ("NCCHC") standards regarding mental health, to give each inmate private, comprehensive mental health examinations on a yearly basis, to monitor and assess the medication levels of inmates receiving psychotropic medications, and to house the inmates with psychosis and severe mental illnesses separately from the other inmates.
>
> MDOC argues that it was already in compliance with ACA standards and, somewhat contradictorily, that MDOC has already begun the process of selecting a new medical vendor that would comply with ACA and NCCHC standards. Once again, MDOC's assertion that it was already on the path towards compliance is insufficient to moot the issue. Further, the injunction does not require only ACA compliance. In any event, MDOC's assertion that it is already in compliance with ACA and NCCHC standards is incongruous with the trial court's findings, including the statement that 'the mental health care afforded the inmates on Death Row is grossly inadequate'....

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

> We agree that the conditions of inadequate mental health care, as found by the trial court, do present a risk of serious harm to the inmates mental and physical health. Again, the obvious and pervasive nature of these conditions supports the trial court's conclusion that MDOC officials displayed a deliberate indifference to these conditions. Thus, this injunction was justified by an Eighth Amendment violation and is affirmed.

Finally, the appeals court seemed particularly incensed by the state's argument that Mississippi State Penitentiary's ACA accreditation was proof that the conditions in question did not violate the Eighth Amendment. As opined by the court: "…it is absurd to suggest that the federal courts should subvert their judgment as to alleged Eighth Amendment violations to the ACA whenever it has relevant standards. Additionally, the ACA's limited inspections are not to be binding as factual findings on the magistrate or on this court. While compliance with ACA standards may be a relevant consideration, it is not per se evidence if constitutionality."

Tennessee

A federal lawsuit has accused staff at the Lauderdale County Jail in Ripley of using tear gas and pepper spray to punish inmates with mental illnesses. The compliant asks U.S. District Judge Jon McCalla to hold the county in contempt of court for violating orders stemming from a lawsuit filed in 1993. That lawsuit, which alleged various unconstitutional conditions of confinement, helped pressure the county into building a new jail that opened in 1996. It had also led Judge McCalla to subsequently issue an order prohibiting jail staff from using chemical agents "as a form of inmate discipline."

Filed in July 2004 by Memphis lawyer Robert Hutton, the new complaint accuses jail officers of using pepper spray on inmate Lemon Russell and pumping tear gas into his cell as punishment for behavior arising from his mental illness. "There is no legitimate penological reason for these chemicals to have been used upon Russell," states the complaint, which described Mr. Russell as mentally ill. "He has not been regularly provided his medication while incarcerated….As a consequence, Mr. Russell has on several occasions acted out, yelling, screaming and/or flooding his cell." The compliant alleges that Mr. Russell's cell was filled with "tear gas or a similar chemical agent" at least six times over a two-month period. Mr. Russell has been confined in the Lauderdale County Jail for not paying court costs and fines following an arrest for misdemeanor theft and vandalism.

The complaint also accuses jail staff of improperly using a chemical spray on another inmate, Ernie McCage, who was also described as mentally ill and "very boisterous." Mr. McCage was jailed in June 2004 for disorderly conduct and resisting arrest and "sprayed with a chemical agent while he was hogtied," according to the complaint. "All of this conduct constitutes the use of chemical agents as a form of punishment upon mentally ill inmates."

Texas

In December 2004, a federal lawsuit was filed seeking unspecified monetary compensation for three mentally ill men who were reportedly denied medical care while in custody at the Dallas County Jail. The lawsuit, which names Dallas County, the Sheriff's Department, former Sheriff Jim Bowles and the county hospital district, alleges that jail policies failed to provide adequate care for mentally ill inmates, causing suffering, injury or death.

According to the lawsuit, one inmate (Clarence Grant Jr.) died in custody in 2003 from neglect, while another (James Mims) nearly died of dehydration and kidney failure after jail officers allegedly denied him water for nearly two weeks in 2004. A third mentally ill man unable to physically care for himself was released last year without his medication or notification of his family and was found wandering the streets.

Plaintiff attorney Mark Haney told the *Dallas Star-Telegram* on December 31 that inmates at the jail are often forced to wait weeks or months to see medical staff and receive their medications. "This is not Abu Ghraib. These people are not war combatants. This is Dallas, Texas, and these are pretrial inmates ... that need to be taken care of humanely. We're trying to fix that," he stated.

Officials with the Dallas County Commissioners Court, Dallas County Sheriff's Department and the Dallas County Hospital District have declined comment, saying they had not seen the lawsuit. The county and county hospital district have a contract with the University of Texas Medical Branch at Galveston to provide medical services to the jail.

One practice criticized in the lawsuit is a jail policy that requires all prescribed medications that arrive with mentally ill patients to be confiscated without arrangements to replace them during incarceration.

James Mims, 53-years-old, was rushed to a local hospital on April 9, 2004 after jail trusties found him on the floor of his cell, semi-conscious, incoherent and soaked in his own waste, according to investigators from the sheriff's department. Emergency room nurses immediately saw that Mr. Mims was critically ill, suffering from severe dehydration and kidney failure. He had pressure sores on his shoulder, back and hip, indicating that he had been lying unaided for a long period of time, nurses told investigators. Mr. Mims spent three months in at the hospital.

In 1978, Mr. Mims was charged with two counts of attempted murder in the shooting of two Dallas police officers during a domestic standoff. He was declared mentally incompetent to stand trial, and has been confined in state mental hospitals since that time. Dallas County judges and juries have repeatedly found him mentally ill and incompetent to stand trial. It was another such hearing that caused deputies to return him to Dallas from a state hospital on February 9, 2004. While housed in the Dallas County Jail until April 9, investigators wrote, Mr. Mims never received his psychotropic medication, and was not seen by the jail's mental health staff despite several referrals from correctional staff. For at least 13 days, Mr. Mims was not given any water because the officers had cut off the water supply to his cell, and he was too mentally unstable to request water, investigators wrote. Officers stated they cut off the water supply to his cell because he had flooded the room, but jail records did not support those claims, investigators found. At the time, the jail had no policy limiting how long time an inmate could go without water or even

documenting how long the water had been cut off. The jail has since changed its policies.

Clarence Grant, suffering from paranoid schizophrenia, was transferred from a state mental institution to the county jail for a court appearance in February 2003. The lawsuit alleges that he was denied his medication during a 17-day confinement which led to his death on February 21, 2003.

On June 15, 2003, 38-year-old Kennedy Nickerson, who also suffers from paranoid schizophrenia, was transferred from a state mental institution to the county jail for a court appearance. Medical staff indicated in reports sent to the jail that the inmate was unable to care for himself and should be released with proper medication and a referral to a mental health agency. Mr. Nickerson was released from the jail on June 21, but without his medication and his family being notified. He was found five days later wandering the streets dehydrated, suffering from a 108-degree fever and having seizures.

The Dallas County Jail's medical policies have been the subject of previous lawsuits. In 2002, a federal appeals court upheld a $250,000 award to a paraplegic inmate who alleged that jail policies prevented him from receiving the medical care prescribed by his doctors. A pending lawsuit filed by relatives of a mentally ill woman who died in custody in March 2002 cites the confiscation of her psychiatric medication and the lack of medical treatment as reasons for her death.

Iowa

In November 2004, state Department of Corrections (DOC) Director Gary Maynard told the Board of Corrections (BOC) he accepted responsibility for the suicides of several mentally ill inmates at the Iowa State Penitentiary in Fort Madison, and pledged to take immediate steps to address the problem. Four inmates have committed suicide over a 21-month period in the Clinical Care Unit of the prison. "The question comes up…. who is responsible? Whose fault is it? There is no question about it. The responsibility for carrying out the mission is mine," Director Maynard told the BOC. He planned to ask the U.S. Justice Department's National Institute of Corrections for technical assistance in assessing suicide prevention practices at the facility (see page 15).

Opened in 2002 at a cost of approximately $26 million, the prison's Clinical Care Unit houses up to 170 inmates with mental illness. Ironically, the facility was built in response to a federal lawsuit that challenged living conditions for mentally ill inmates housed in the Iowa State Penitentiary. The most recent suicide in the Unit occurred on November 1, 2004 when 24-year-old Nathan Watson died of suffocation after using a shoelace to tie a plastic bag around his head. A medical examiner determined that Mr. Watson had been dead for more than seven hours before a correctional officer discovered that he had committed suicide.

Following the BOC meeting on November 5, chairwoman Suellen Overton told the *Des Moines Register* that she was satisfied Director Maynard was doing everything possible to investigate the deaths and to prevent future suicides. "It is always difficult when you are dealing with mentally ill inmates. Events like this are going to occur, but it is our job to help minimize them," said Ms. Overton, also an attorney.

Director Maynard also spoke on November 5 to a state conference of the Alliance for the Mentally Ill. He was joined by Dr. Harbons Deol, DOC medical director. They said that approximately 1,700 of the 8,600 inmates in its prison system were mentally ill. "We may not choose to have the mentally ill in prison, but they are here," stated Director Maynard, a former prison psychologist. "Once they are here, we need to do everything that we can to help them."

Both Director Maynard and Dr. Deol stated the state prison system needs additional mental health staffing. The entire state prison system has only two psychiatrists to serve nine prisons. "It is unthinkable," Dr. Deol stated. "I think we need at least two or three more psychiatrists." Director Maynard stated only a part-time psychiatrist provides services to the Clinical Care Unit. "That's not enough. We know that. It is a question of funding," he stated.

In 2003, both Michael Madigan and Isaiah Gathright committed suicide in separate incidents while confined in the Critical Care Unit. Mr. Madigan suffocated to death on May 3, 2003 after he shoving toilet paper, hair and underwear into his mouth. He managed to commit suicide despite being placed in a cell monitored by closed circuit television. He was also left unobserved for approximately two hours. On August 24, 2004, Alan Leak died from an overdose of psychotropic medication in the Critical Care Unit. In a separate, but related incident, Doreen Kneipp committed suicide on August 28, 2004 by jumping out of a third-floor window in the special needs unit at the Mount Pleasant Correctional Facility.

Mr. Madigan's suicide, as well as the deaths and severe injuries to three other inmates in the state prison system, prompted Governor Thomas Vilsack to appoint a task force to investigate inmate deaths. The task force was led by state Ombudsman William Angrick II. In the midst of the Clinical Care Unit suicides, the Citizens' Aide/Ombudsman Report of Task Force into Critical Incidents within the Iowa Prison System (http://staffweb.legis.state.ia.us/cao) was released in October 2004. The task force found that the inmate deaths had several common threads — all the victims were mentally ill, placed on close observation status, and perceived by staff to be manipulative. The task force concluded that staff were sometimes too quick to assume that strange behaviors were intentional attempts to gain special treatment. "The unfortunate result is under-diagnosis, which can lead to unfair punishment of prisoners whose unacceptable behaviors are actually driven by their mental illness. Of course, the ultimate tragedy is when over-concern about malingering leads mental health staff to miss what would otherwise be clear signs of impending suicide." The task force report recommended additional mental health training for correctional officers, as well as additional mental health staff to provide emergency psychiatric intervention.

Ombudsman Angrick also vowed to launch an investigation into the death of Nathan Watson, expressing concern for the excessive amount of time the inmate was left unobserved. "This is troubling. I don't understand why and I want to know why," he told the *Des Moines Register*.

Finally, in early December 2004, tragedy struck the prison system once again when 28-year-old Kristopher Greer committed suicide in a general population cell at Iowa State Penitentiary. Although Mr. Greer had a history of mental illness, he was not housed in the Clinical Care Unit. An investigation is pending.

Indiana

The Indianapolis Police Department is investigating the recent death of a 45-year-old man who apparently made good on a promise to hang himself if arrested. On October 9, 2004, Jeffrey Brown was found death in his cell at the Marion County Arrestee Processing Center. During his arrest several hours earlier on a charge of aggravated assault, Mr. Brown threatened suicide to the arresting officers. A "trip ticket" was written that documented the threat. Upon arrival at the Arrestee Processing Center, Mr. Brown was placed in a holding area where intake officers could provide closer observation. The area contains a row of cells. At approximately 3:20pm, an intake officer allowed Mr. Brown to enter an unoccupied cell to use its toilet, which is behind a privacy screen. Approximately 12 minutes later, a closed circuit television monitor showed that Mr. Brown took off his jacket, tied one end around his neck and the other end around the privacy screen, sat down and lost consciousness. Approximately 14 minutes after that, Mr. Brown was found by an officer. Medical personnel arrived and transported the victim to a local hospital where he was subsequently pronounced dead.

New Mexico

In May 2002, the Civil Rights Division of the U.S. Justice Department initiated an investigation into conditions of confinement at the Santa Fe County Detention Center. The facility is privately operated for the county by the Management and Training Corporation (MTC). In March 2003, a scathing report was issued that cited numerous deficiencies and constitutional violations in the facility, including a description of the egregious circumstances surrounding the January 2002 suicide of 27-year-old Tyson Johnson [see ***Jail Suicide/Mental Health Update*** (2003), 12 (1): 20]. The Justice Department threatened to file a lawsuit unless the county agreed to various remedial measures. Although denying that they ever violated the constitutional rights of inmates, Santa Fe County (and MTC) decided to settle the case on November 1, 2004 by entering into an agreement "for the purpose of avoiding the risks and burdens of litigation and in order to describe conditions both parties wish to see maintained at the Detention Center."

The agreement calls for corrective action in the areas of medical and mental health care, suicide prevention, security and safety, quality management, and staff training and supervision. The suicide prevention measures include the following:

> **Policy:** The County shall revise existing suicide prevention policies as necessary to include: (1) staff training; (2) identification and screening of potentially suicidal inmates; (3) appropriate housing for suicidal inmates; (4) effective watch procedures, duration and conditions of monitoring; (5) suicide intervention procedures, and (6) receipt of transmission to appropriate persons of reports of inmate suicidal behavior and information needed to protect suicidal inmates.
>
> **Training:** The County shall train clinical, mental health and correctional officer staff who have inmate contact regarding: (1) the warning signs and symptoms of inmates who are risk of suicide; (2) why correctional environments are conducive to suicidal behavior; (3) high-risk suicide periods; (4) potential predisposing factors to suicide; (5) procedures and methods for responding to inmates who exhibit such risk; (6) observation techniques; (7) searches of inmates who are placed on suicide watch; (8) emergency procedures for responding to a suicide attempt; (9) location and use of cut-down tools and other emergency response supplies; and (10) how to refer inmates with mental illness needs to appropriate care. All facility staff who have inmate contact shall have initial training and refresher training every two years.
>
> **Suicide Watch:** The County shall revise as necessary policy, procedures and practices to ensure that inmates placed on suicide watch are supervised sufficiently to maintain their safety and to address the following requirements. When staff initially place an inmate on observation, the inmate shall be strip searched and monitored until a mental health professional conducts a suicide risk assessment, determines the degree of risk, and writes appropriate orders. Such orders may include assignment of a specially trained inmate to monitor an inmate on suicide watch, as a supplement to sufficient correctional officer supervision only. On a case-by-case basis, it may be acceptable to order the housing of two suicidal inmates in the same cell. Until such assessment, inmates shall be placed in gowns recommended and approved for use with suicidal patients. Mental health staff shall provide services initially as soon as possible and then as medically appropriate to all inmates on suicide watch Monday through Friday. Mental health trained nurses may provide this function on weekends. On-call mental health staff shall respond as necessary to provide care to inmates newly placed on suicide watch on the weekends. Inmates shall only be removed from suicide watch after approval by mental health staff after a suicide risk assessment indicates it is safe to do so. Mental health staff shall write appropriate discharge orders, including treatment recommendations and required mental health follow-up. The County shall revise observation logging procedures and practices to ensure that sufficiently detailed information about an inmate's suicide watch is recorded at appropriate intervals. At the time of placement on suicide watch, medical or mental health staff shall write orders setting forth the conditions of the watch, including, but not limited to allowed clothing, property, and utensils. These conditions shall be altered only on the written instruction of the mental health staff, except under emergency circumstances.
>
> **Location of Suicide Watch:** The County shall review and alter as necessary one medical area cell for inmates to be placed for suicide watch, ensuring that physical features that could aid in completion of a suicide are altered or removed, and that staff conducting suicide watch can see every point in the room. Only cells in the medical area shall be used for suicide watch. On occasions when more than one inmate must be placed on suicide watch at the same time, the County shall institute precautions to maintain the safest environment possible for those inmates, and ensure adequate supervision.

Risk Assessment: The County shall ensure that any inmate showing signs and symptoms of suicide is assessed using an appropriate suicide risk assessment instrument.

In June 2004, the family of Tyson Johnson settled their federal lawsuit for an undisclosed amount. The Memorandum of Agreement Between the United States and Santa Fe County can be accessed at the Justice Department's website: www.usdoj.gov/crt/split/documents/split_santafe_agree_11_1_04.pdf

Maine

In August 2004, the mother of a 24-year-old man who committed suicide two years ago at the Kennebec County Correctional Facility in Augusta filed a lawsuit against both a sergeant and contract nurse at the facility. Jason Rozell was found hanging in his cell in April 2002. His death led to widespread scrutiny of procedures at the jail after it was learned his mother had called the jail before his death to warn staff that her son was potentially suicidal. The state Department of Corrections, Kennebec County Sheriff's Office, and the Augusta Police Department each investigated the case and came up with varying opinions on whether either jail staff or the nurse bore responsibility for Mr. Rozell's death.

Walter McKee, attorney for the family, told the *Kennebec Journal* that it took two years to research the case because there were so many aspects to explore. "We took some time to wait and file suit in this case because we wanted to make sure we had all the information," he stated.

The lawsuit, filed in state court, lists two defendants: Patricia John, a licensed practical nurse who worked at the Kennebec County Correctional Facility through Allied Resources for Correctional Health at the time of Mr. Rozell's death; and Cathy Campbell, a sergeant at the jail. According to the complaint, Mr. Rozell showed signs of severe depression after being incarcerated at the facility on March 29, 2002. The complaint alleges that Mr. Rozell called his mother (Tammy Norton) on April 5, 2002, and threatened suicide. Ms. Norton immediately called the jail and informed staff of her son's suicide threat. During the next two days, Mr. Rozell allegedly tried to hang himself and submitted a request for mental health services, which was passed along to Nurse John the morning of April 8, the day of his death.

The complaint alleges either Nurse John spoke with Mr. Rozell and failed to report the assessment of suicide risk to jail staff or that Nurse John reported Mr. Rozell's condition to jail staff and Sergeant Campbell failed to place the inmate on suicide watch. As offered in the complaint, "It is now clear that one of two series of events occurred on April 8 ... either Nurse John evaluated Rozell and was under the belief that Rozell was a suicide threat and needed to be placed on a suicide watch, told Campbell this, and Campbell ignored Nurse John's recommendation; or Nurse John evaluated Rozell and failed to recognize the clear signs that Rozell was such a threat despite the many clear warning signs."

Both Nurse John and Sergeant Campbell have denied any wrongdoing in Mr. Rozell's death. In her written response or "Answer" to the complaint, Nurse "John admits that she went to Rozell's cell and spoke with Rozell concerning the suicide threats ... she advised Kennebec County Correctional Facility that Rozell was a suicide risk and that he needed to be placed on suicide watch." In her written response, Sergeant Campbell has disputed Nurse John's version of the events. Stay tuned.

Virginia

An investigation into the suicide of an inmate found that poor judgment by a booking officer was a contributing factor to the death in the Virginia Peninsula Regional Jail in Williamsburg. Brian McKeehan, 37-year-old, a master sergeant in the U.S. Army who had recently returned from Iraq, hung himself inside his cell on October 9, 2004. Although the investigation by the James City/ County Police Department found that the jail had proper policies and procedures for identifying and responding to suicidal inmates, the booking officer "did not properly review the written information presented in the booking process," Jail Administrator John Kuplinski told the *Virginia Gazette* on October 30, 2004.

And while jail officials emphasized that Mr. McKeehan never gave any indication of being suicidal when he was booked into the facility on October 8, documentation in the jail's possession suggested otherwise. In the weeks after his returned from deployment in Iraq, the York County Sheriff's Office was called to the McKeehan home six times related to the belief that his wife was having an affair with a neighbor while he was gone — an allegation she denied. On September 13, he was charged with malicious wounding in connection with a fight with his neighbor. He was placed on suicide precautions in the jail and later released on bond. On September 20, Melissa McKeehan called the sheriff's department again after her husband threatened to kill himself following an argument. He then left the home. A deputy found him several hours later at a local motel. "He was very agitated and had been drinking," and admitted taking medication that he had been given by a military doctor to help him sleep, the incident report said. Mr. McKeehan said he wanted to kill himself to get back at his wife, but then realized that he needed to be with his children. Mr. McKeehan was subsequently admitted to a psychiatric hospital for treatment. He was released approximately one week later.

On October 8, Mr. McKeehan was arrested for assaulting his wife. A magistrate ordered him held without bail and noted on the commitment form that the "Accused should be evaluated and is a danger to self and others. Was recently in a psychiatric hospital." Jail Administrator Kuplinski stated that had the booking officer followed correct procedures, Mr. McKeehan would have been placed on suicide precautions. He was dead less than 12 hours later.

Washington (State)

In October 2004, county officials agreed to pay $1.6 million to the parents of a young Texas man who died in 2001 while in restraints at the Jefferson County Jail in Port Hadlock. According plaintiff attorneys Edwin Budge and Erik Heipt, it is the largest such award against the county and one of the largest ever for an excessive force case in the Pacific Northwest.

According to the federal lawsuit filed earlier, 23-year-old Kevin Wayne Bledsoe "lost his life after members of the Jefferson County Sheriff's Office sprayed him in the face with pepper spray, tied him up in a controversial 'hog-tie' position using a homemade rope, put a hood over his injured and bleeding head, brought him to the Jefferson County Jail

rather than to a hospital, and held him face down on the floor of an isolation cell until he suddenly went limp and lost consciousness. . . .Instead of immediately securing emergency medical care for the young man, the officers then inexplicably removed all of his clothing, left the cell, and closed the door behind them — leaving him alone, face down, motionless, stark naked, with a pool of blood around his head. They did not return until it was too late."

Former Jefferson County Administrator David Goldsmith, who continued to handle the case for the county, told the *Kitsap Sun* he was reluctant to comment because there was a confidentiality agreement included in the settlement that forbids either party to discuss it publicly. He would not confirm the settlement amount. Erik Heip, attorney for the family, stated there was no such confidentiality agreement, but agreed that the facts of the case were still in dispute. Mr. Goldsmith said the county did not regard it as an excessive force case.

An internal investigation of Mr. Bledsoe's death was performed by the Clallam County Sheriff's Office. Mr. Goldsmith said that none of the officers involved in the case was disciplined for their actions. "The officers acted pretty much according to the rules," he told the *Kitsap Sun*, except for the question of whether Mr. Bledsoe should have been taken to a hospital. An independent pathologist determined the death to be accidental, brought on by methamphetamine and an existing heart condition. "It's certainly a shame the individual died, but in all likelihood he would have anyway," Mr. Goldsmith said, thus raising the question of why then would the county settle the case for the record amount.

Alabama

In August 2004, Sheriff Chris Curry said his department will continue to review policies and procedures at the Shelby County Jail in Colombiana following the third inmate suicide of the year, and second of the month. "Having had two other deaths in the jail in a short period of time as we prepare to move into the new facility is very disturbing," the sheriff said in a prepared statement. A new jail was completed recently, but not yet in use. During a news conference, Sheriff Curry said his department constantly examines its policies and has found nothing since the first suicide in May 2004 that required a policy change in the 114-bed jail. "Our employees are very diligent," Curry said. "They're doing their job. The checks and balances are in place to the best of our ability."

Melvin Wade Harris was found hanging in his cell on August 26, 2004. On August 3, David Earl Lee was found hanging in his jail cell. On May 1, Kenneth Wayne Moss was found hanging in an medical isolation cell at the jail.

Sheriff Curry did not know whether the move into a new jail will prevent future inmate deaths. The new jail, however, will have better technology, including more cameras, he said. Shelby County Attorney Frank C. Ellis said he spent the day looking into Mr. Harris' death and had not found any wrongdoing on the part of jail employees. "I don't see anything there that they should have done differently," he told the *Birmingham News*. "They didn't have any threats of suicide. It is unfortunate that we had this one, and it is unfortunate that we had the others." ❑

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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