JAIL SUICIDE/MENTAL HEALTH UPDATE

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CUSTODIAL SUICIDE: YET ANOTHER LOOK

by
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Introduction

*About 14 years ago, **Update** Editor Lindsay Hayes invited me to do an article for the **Update**. It appeared as Fred Cohen (1992), "Liability for Custodial Suicide: The Information Base Requirements," **Jail Suicide Update**, 4 (1). As you will know, "Mental Health" has been added to the **Update's** marquee implicitly emphasizing the close, but for me not inevitable, relationship between suicide and mental disorder, i.e., the absence of mental health.*

In that article I explored the requisite information base needed to show deliberate indifference when a custodian was charged with causing or failing to prevent a captive's suicide. The Supreme Court had not yet clarified the definition of deliberate indifference, but the majority of federal courts insisted that custodians have knowledge of a recent suicide attempt or a recent, credible threat before being found viable. While I argued then for a custodian's duty to access readily available records relevant to the risk of suicide and placed that argument in the framework of a "should have known" approach to deliberate indifference, that argument did not prevail. It would not be my only losing argument.

Farmer Ruminations

Since that 1992 article, the Supreme Court of the United States decided *Farmer v. Brennan*,[1] which defined for the first time the Court's oxymoronic term, deliberate indifference. The Court adopted what I have elsewhere termed the "hot version" of recklessness as the mental state required for a constitutional tort related to medical, mental health, and dental care as well as the constitutional duty of a custodian to provide a reasonably safe environment for those in his charge. By "hot version" I simply mean requiring actual knowledge of a high degree of risk v. the milder version of "should have known." I will return to "hot" and "mild" metaphors in some detail shortly.

Depending on one's theory of causation, custodial suicide cases may be fashioned on a theory of inadequate medical care or failure to protect. The "hot version" of deliberate indifference, however, will apply to either theory of cause and putative liability.

The key to understanding *Farmer* is its formal insistence on "actual knowledge," as opposed to the milder "should have known." Does the actual knowledge — of what, shortly — requirement lighten the burden or make it more difficult for plaintiffs? It clearly makes the task for plaintiffs about as difficult as it can be short of requiring specific intent to cause the death of another, a mental requirement in criminal law for murder.

Professor James E. Robertson correctly explains *Farmer's* "actual knowledge" as follows:

- To incur liability, "the official must *both* be aware of the facts from which the inference could be drawn that a substantial risk of serious harm exists, *and* he must also draw the inference.
- When awareness can be inferred from circumstantial evidence, especially when the risk is "obvious," the trier of fact can conclude that the official "must have known" of the danger.
- While ignorance of obvious risks will remain a defense, "[the] official would not escape liability if evidence showed he merely refused to verify underlying facts that he strongly suspected to be

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INSIDE. . .

> true, or declined to confirm inferences of risk that he strongly suspected to exist."[2]

Actual knowledge as a component of recklessness would seem to be inherently a rather straightforward concept and if not inherently so, then certainly by contrast with the "should have known" standard. Regrettably, that is not the case.

The "should have known" version of recklessness, at times expressed as "had reason to know" is more an expression of duty than a description of knowledge-as-facts. The "had reason to know" concept in tort law often arises where a defendant had some information that would (or should) have led directly to the relevant facts or conditions: You knew it was raining, visibility was poor, and yet you drove 25 miles over the speed limit and struck a pedestrian who appeared out of nowhere. The driving created a high degree of risk and one should have known that an errant, yet unknown, pedestrian was within the scope of the risk of harm. Our hypothetical driver knew the facts and should have been aware of the risks.

Should have known, in turn, need not rest on a factual platform from which other facts or conditions will be inferred. In custodial suicide cases, actual knowledge of the risk most often relates to an inmate's or detainee's recent credible threat to commit suicide, a recent suicide attempt, or a clinician's clinical assessment that the suicide risk is probable and imminent.

A "should have known" situation may arise, for example, where a detainee has obvious scars on his arms and neck indicating "hesitation marks," where suicide risk records are readily accessible but not reviewed; where a custodian hears of an undated suicide attempt, there are hospital records showing suicidal ideation, and the detainee acts "strangely."[3] These "should have known" tidbits provide some information and some reason to go forward and obtain additional information. The courts, however, do not require that step. "Should have known" implies a requirement that one draw an inference from limited facts or that one should have gone further, uncovered additional facts, and then acted to reduce or eliminate the risk that emanates from such facts. With the adoption of the actual knowledge requirement, however, should have known discussions either are wistful or merely comparative.

Returning to the "actual knowledge" requirement of Farmer, we may ask: How do we know what someone else knows? There is no brain scan for this of which I am aware. There is no exact equivalent to police interrogation with *Miranda*-like warnings where the defendant is asked to admit knowledge.[4] Typically we know what another person knows if we are told by that person or, more likely, by inference. *Farmer*, as indicated earlier, left open the actual knowledge-by-inference approach where the risk is obvious (thus known?) and the official therefore must have known of the danger. Thus, the Court established an onerous actual knowledge requirement and also established at least one method for proving such knowledge: An inference drawn from circumstantial evidence.

Has this narrow opening paved the way for newfound success for custodial suicide plaintiffs?[5] Professor Robertson finds that even good "must have known" arguments fail and what I had earlier termed a judicial premium on ignorance continues post-*Farmer*.[6]

A "must have known" case might be made where, so to speak, an official turns his back or closes his eyes and ears to the obvious: An "I don't know what I have to live for" plaint on admission to jail, or a cell with windows covered by towels housing a very despondent occupant. "I didn't know," "I didn't see," "I didn't realize" are all pleas available to custodians but may be nullified by "you must (not should) have known."

In one recent case, the question was whether an officer aware that a detainee is in a suicide observation cell under precautions should be held to knowledge that the cell's occupant is a suicide risk?[7] The question would seem almost frivolous except for Federal District Court Judge Griesbach tying himself in verbal knots over real v. perceived risks and high v. low risks.

All risks of the sort discussed here are perceived; they are not precise mathematical or actuarial predictions. Let us stipulate that the precautions here represent a conservative, prudent decision. That means only that while there was a perceived risk, it may not have been as likely or imminent as would usually exist in such precautions.

Judge Griesbach thought the risk was merely perceived but perhaps without realizing it, he was actually saying there was no deliberate indifference. Pre-trial detainee Taylor hung himself during a ten-minute dark interval in his observation cell when he managed to turn out the cell lights. Otherwise jail officials acted reasonably and protectively and I doubt that there is even negligence here, let alone deliberate indifference.

Custodial suicide cases are fact driven and often nuanced in ways that defy efforts to find logical or precedential consistency. As I have written elsewhere and alluded to here:

> The defendants must be shown to have had actual knowledge of a particular vulnerability to suicide; this knowledge must create a strong likelihood, as opposed to the possibility, of suicide; and this "strong likelihood" must be so obvious that a layperson would easily recognize the need for some preventive action. Parenthetically, the courts seem to be unaware of the fact that they are borrowing the "obvious to a layman" phrase (or test) from prison and jail mental health cases, which state that a mental illness or medical need is serious if it would be obvious to a layperson that treatment was needed. (citations omitted)[8]

Liability often will turn on the arcane actual knowledge requirements just discussed. Absent a current, credible threat or a relatively recent prior attempt, liability likely cannot be established. Legal battles tend to be waged on the meaning or seriousness of a current threat; what actually constitutes a threat; and on the question of what actually was known about a decedent's prior mental health or suicide attempt history. With that in mind, then, let me explore one fascinating case in some detail to put some meat on the barebones of this somewhat abstract discussion of deliberate indifference.

Woodard v. Myres

Justin Farver committed suicide in 1998 by hanging while detained in the Lake County (Ill.) Jail on a charge of attempting to rape his 12-year-old niece. The Administrator of his estate sued for damages in

federal court naming a variety of custodial and medical staff, along with Correctional Medical Services (CMS) as defendants.

In *Woodard v. Myres*,[9] Federal District Judge Gettleman denied the various defendants' motions for summary judgment. *Woodard I* dealt primarily with the motions of Nurse Karen Dean and CMS, while *Woodard II* dealt with other defendants and facts that emerged after the initial ruling. Plaintiff, then, was enabled to move ahead and given the opportunity to present the case to a jury.

In denying these motions the court found that a reasonable jury could conclude there was liability on behalf of Nurse Dean; Joel Mollner, a social worker; Dr. Fernando, a psychiatrist; and CMS, the nation's giant correctional health care provider. Thus, we have a relatively rare example of success for plaintiffs.

Farver was 23-years-old in the fall of 1998 and afflicted with cerebral palsy. He had finished one year of college and was living with, and helping, his brother and sister-in-law raise their six children in Zion, Illinois. On September 24, 1998, Farver was arrested on a seven-count felony indictment alleging that Farver attempted to rape his 12-year-old niece at knife-point. Farver was taken to the jail and evaluated by Nurse Dean, who, at that time, had been a registered nurse for approximately two years and had conducted 30 to 40 similar evaluations. Nurse Dean's evaluation consisted of a medical history, a medical screening, and a mental health screening.

Through her evaluation, Nurse Dean learned about Farver's cerebral palsy; that he had attempted suicide in 1995 by trying to jump in front of a train; that he was later hospitalized for psychiatric problems; and that he received outpatient mental health treatment at Dixon Correctional Center in May 1998. Dean also learned that Farver was worried about major problems other than his legal situation (he reportedly said that he was "always worried"), that one of Farver's parents had attempted to commit suicide, and that Farver had a history of violent behavior. In addition to noting this information on Farver's CMS Mental Health Screening form, Nurse Dean circled "Yes" in box number eight, which asked whether Farver "expresses thoughts about killing self." She did not, however, report the matter to the Shift Commander, as required by jail policy. Such a report triggers a number of protective and treatment intervention measures.

Farver initially was placed in the jail's medical pod where routine mental health examinations are performed. It appears also that he was celling in that unit at the time of his death.

Shortly after admission to the jail Farver made multiple attempts to contact his niece (the young woman he allegedly attempted to rape at knife-point). According to a statement by one of his fellow inmates, Farver spent the better part of the day on October 12, 1998 in bed, but he came out to use the phone very abruptly two times that evening. Apparently, Farver had called his brother, who refused to take his call and refused to allow Farver to speak to his niece.

The jail staff was notified of Farver's phone call and he was placed on "lockdown" (i.e., he was not allowed to leave his cell for any reason) as a result. The next morning, the same inmate heard a deputy tell Farver that he had been warned enough and that this time his lockdown period would be indefinite. That same inmate saw Farver "pacing and staring at the hooks" on the wall of his cell (presumably intended for the hanging of hand towels) between 11:00am and noon later that day. At 12:51pm that afternoon, Officer Myers entered the medical pod to assist an inmate to his cell following a visit to court. According to Officer Myers, at that time Farver was lying in his bed beneath his blankets, moving around a little. Approximately nine minutes later, another inmate alerted Officer Myers that Farver had hanged himself. Although Officer Myers and others attempted to revive Farver, he was pronounced dead on arrival at the local hospital.

Liability — if liability exists — begins with Nurse Dean's handling of a key question on the jail's intake form. The question asks if the inmate "expresses thoughts of killing self." Nurse Dean marked the answer "yes" explaining later that she (and others) interpreted "expresses" as including past thoughts and when the "yes" referred to the past, the shift commander need not be notified. That notification would have led to an immediate mental health evaluation, which, in turn, could have led to suicide precautionary measures; measures that never were taken.

Nurse Dean also failed to complete the "Summary" and "Disposition" sections of the intake form. The form allows the following choices:

1. No mental health problems;
2. Mental health problems requiring routine follow-up;
3. Chronic mental health problem (a) Mental Illness; (b) Developmental Disability; or (c) Other;
4. Acute mental health problem (a) Psychosis; (b) Suicidal; or (c) Other;
5. Potential withdrawal from substance abuse.

Similarly, the "Disposition" portion of the form gives the writer the following options:

1. Approved for General Population: No Mental Health Referral;
2. Approved for General Population: Routine Mental Health Referral;
3. Special Housing: Mental Health Referral ASAP;
4. Suicide Precaution Procedures: Mental Health Referral ASAP;
5. Psychiatric Referral;
6. Medical Monitoring for Potential Withdrawal.[10]

Dean testified that she did not complete these sections because she knew that Farver was headed for the medical unit and within two weeks he would be evaluated there. Her credibility was somewhat undercut when a fellow nurse testified that Dean resisted CMS's training on how to conduct intakes; she apparently did not want to be told what to do. The implication is that Nurse Dean either did not know what to do or, if she did, she would not always follow the rules.

On October 1, 1998, Farver received a mental health evaluation from Social Worker Mollner. Mollner noted on Farver's Mental Health Intake Evaluation form that Farver was not currently receiving psychotropic medication and that while he was evaluated by Mollner to be "coherent, oriented, and rational," Farver felt, "anxious, depressed, and not himself." In response to the question, "History of suicidal ideation or behavior?" Mollner circled "Yes," and added the following:

"Over 10 self-destructive episodes. Most recent, 1995. Feels current suicidal proclivities as he knows what he did was wrong [and he is] not looking to spend rest of his life in prison. Over 10 psychiatric hospitalizations, most recent 4/95, for suicide attempt. Single, no children. Employed in child care [and] has cerebral palsy. Felt anxious."

In response to "treatment plan," Mollner wrote: "depressed, angry." Several days later, Mollner referred Farver to the jail psychiatrist, Dr. Fernando. Mollner did not request that Farver be placed on suicide watch, erroneously believing that Farver's placement in the medical pod meant that he must have already been on suicide watch.

We should note that the potential threat of suicide here relates to the past, which is not so unusual, while Mollner found Farver to be currently rational and coherent. The incidents of self-destruction and hospitalization also are about three-years-old. The picture is that of an obviously disturbed young man, rather plainly one who is eligible for mental health observation and treatment. Is it, however, also a picture of an imminent suicide threat and a requirement of suicide-relevant care?

Dr. Michael Fernando saw Farver on October 11, 1998 noting that Farver asked to see him because of recent suicidal thinking and feelings of worthlessness. The doctor prescribed Zoloft, which takes weeks to cause improvement, and Ativan, a tranquillizer that works much more quickly. Dr. Fernando also mistakenly believed that Farver was on suicide watch. Again, as with Nurse Dean, there was a lack of understanding as to what sort of observation relevant to suicide prevention occurred on the medical pod.

It would be fair to say that the doctor had more reason to be concerned about suicide than Mollner. Does that concern equate with a strong likelihood that suicide was imminent?

Returning to Nurse Dean for the moment, one explanation she offered regarding her failure to believe Farver to be a present suicide risk defies credulity. Farver's earlier suicide attempt involved attempting to be hit by a train. Dean stated, "there was [sic] no trains" in the jail and, thus, Farver's thoughts on suicide were considered irrelevant.

This "explanation" should be distinguished from situations where an inmate is viewed as a suicide risk, is under observation, but commits suicide by a means that staff is found not to have perceived as dangerous.[11] Nurse Dean, then, apparently would not be concerned about Farver's risk of suicide unless he, or the jail, was in very close proximity to railroad tracks.

Mollner served as a gatekeeper for jail suicide watches, although his precise position is not described. A nurse testified that Mollner was very reluctant to place inmates on (expensive) suicide watches; that he actually would rant and rave about some watch requests; and, his attitude chilled others from making such requests.

Mollner's present liability exposure, however, relates to his actual knowledge of Farver's long psychiatric history and his description of Farver as currently anxious and depressed. Still, Mollner asserts he was not subjectively aware of Farver's desire to take his own life.

Liability Unfolds

The court found that a reasonable jury could find actual knowledge of a real suicide potential and that Mollner failed to take steps designed to protect Farver. Mollner also proved to be inconsistent in first claiming "no knowledge" and then his self-comforting belief that Farver would be under suicide observation in the medical pod.

Mollner's failure, finds the court, to place the decedent on suicide watch is enough for a reasonable jury to find deliberate indifference. The doctor took no reasonable, preventive steps and may be found liable.

Dr. Fernando, undoubtedly after meeting with the same defense lawyers as Mollner, claimed he did not know Farver was suicidal and that he also assumed Farmer was on suicide watch in the medical unit. Farver was referred to Fernando because of recent suicidal thinking and he evaluated the decedent as feeling hopeless. The doctor, however, did not equate the history, referral, and current suicide ideation as presenting a current suicide threat. A jury, however, finds the court, could reasonably disagree.

CMS, the contractor, was described by some witnesses as allowing the atmosphere in the jail to become chaotic. Files were described as improper, nurses were seen to administer medication while drunk, and CMS policies were said to regularly go unobserved and unreviewed.

Policy, Procedure, & Accreditation: Necessary But Not Sufficient

Ironically, CMS' Lake County operation had been accredited by the National Commission on Correctional Health Care (NCCHC) for the past 12 years, and CMS' policies and procedures manual was modeled after the NCCHC standards. This alone tells us a great deal about the distinction between merely having acceptable policies and insisting on their observance. The court did not challenge the written text of the policies, but observed that:

> Plaintiff has produced evidence that the staff routinely violated stated CMS' policies with respect to intake, training and suicide precautions, and that these violations were essentially condoned by CMS officials with policymaking authority who failed to take steps to ensure that CMS' policies, as written, were actually enforced.[12]

This custom and practice of failure to intervene and provide services appropriate for suicidal inmates could be found to have caused Farver's death. It is the necessary link required by federal case law when suing a municipality, and CMS agreed that its potential liability here was the equivalent of a municipality.[13]

Putting it Together

Judge Gettleman took a fairly liberal view of the evidence presented here and showed a willingness to impute the possibility of actual knowledge that other federal judges often do not display. Of course, the evidence of chaotic and dangerous conditions at this jail would have helped plaintiff's evidentiary presentation.[14]

In studying both opinions I found it difficult to isolate a crystal clear threat of a present intention to commit suicide. Certainly one might easily conclude that suicide was possible, but one might also conclude that a mere possibility is not the same as the high degree of probability required by federal case law. Defendants may well have hoisted themselves on their own petard by their completion of the intake screening form and inconsistencies as to "no threat" followed by "we thought he was under suicide observation."

Judge Gettleman was quite flexible in his view on what constitutes a threat. In other decisions an inmate states, "I can be suicidal" and bangs his head on a table but the doctor does not think it is serious. Shortly thereafter, the inmate hangs himself and the Fifth Circuit found "no actual knowledge."[15]

Plaintiffs, understandably, want to get to the jury on suicide claims; they need to escape summary judgment and either then settle or go to the jury especially with a sympathetic decedent. *Woodward* clearly is one of the few, somewhat liberal, decisions (obviously from plaintiff's perspective) in this area. There is no recent suicide attempt in the record and no unambiguous, current threat to commit suicide, the usual twin basis for liability.

There also are some unsympathetic defendants, a chaotic environment, evidence of disingenuousness and patent inconsistency, along with a jail that has had more than its share of similar problems.[16] Following trial on February 20, 2003, a jury reached verdicts against defendants CMS and social worker Mollner totaling $1.75 million. Lake County Jail settled its liability with the estate for $60,000.

In 1996, a suicide at this same jail resulted in a judgment against CMS for $1.35 million in compensatory and punitive damages, and for $750,000 against a police detective who knew of the decedent's attempted suicide the night before but told no one at the jail about it.[17]

A Death in Maine

Where the judge in *Woodard* may accurately be said to have been somewhat liberal in his interpretation of events, Magistrate Judge Kravchuk in *Pelletier v. Magnusson*[18] approached a Maine prison suicide with a decidedly different bent.

Ronald Pelletier committed suicide by hanging with his belt while in the custody of the Maine Department of Corrections. The decedent had a long history of mental illness and was believed to be a suicide risk during much of the time he spent in a mental health stabilization unit (MHSU). Pelletier was in regular contact with therapists. On September 15, he was recorded as "struggling miserably" and given an injection of Haldol. He was to be seen again on October 6 to keep the medications "on board," but the suicide occurred on October 3.

After a bench trial, the Federal Magistrate found no deliberate indifference involved. The MHSU director allowed inmates to keep their belts and shoelaces in the belief that an actively suicidal inmate could use other items of clothing while allowing their retention supported inmates' dignity.

WE'RE STILL 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 1996 thru 2005 to:

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At worst, access to the belt used here is described as negligent. Some crucial records, notably a treatment plan for the decedent, somehow turned-up missing. In highly conclusionary terms, the Magistrate simply found no deliberate destruction and drew no inference of intentionally failing to document treatment.

The more dubious finding here relates to the night of the hanging when Pelletier repeatedly banged on his cell bars and told at least one officer he was hearing voices. The officer did not even log this. There is, then, no showing that staff believed decedent was suicidal on the evening in question. Voices, yes; suicide, no;[19] death with dignity?

The Good News

While liability requirements have not eased, the heartening news is that jail and prison suicide rates have declined since 1983[20] when suicide accounted for the majority of jail deaths (56%). By 2002, however, natural causes were the most common attribution for jail deaths (52%) with suicides trailing at 32%.

Suicide rates in state prisons fell from 34 per 100,000 in 1980 to 16 per 100,000 in 1990 and have since stabilized.[21]

Death by suicide in county jails in 2000 totaled 289; in 2001, 315; and in 2002, 314. State prison deaths by suicide in 2001 totaled 169; and in 2002, 168.[22]

The Bureau of Justice Statistics (BJS) reported that:

- Prison suicide rates showed wide variation at the State level. New Hampshire, Nebraska, and North Dakota all reported no suicide deaths during the 2-year period. Another six States had suicide rates of 5 per 100,000 prisoners or lower. Thirteen States had suicide rates of at least 25 per 100,000 prisoners, led by South Dakota (71), Utah (49), Vermont, Alaska, and Arkansas (each with 36).

- In most State prison systems, suicides were rare events. Only 9 States reported as many as 10 prisoner suicides during this period, with 42% of all suicides taking place in four States. California (52), and Illinois (20) reported 142 of the Nation's 337 State prisoner suicides. About half of all States (24) recorded 3 or fewer suicides.[23]

With regard to the 3,300 local jails, BJS reports:

- The 50 largest jail jurisdictions collectively had a comparatively low prevalence of suicide. Inmate suicides accounted for 17% of all deaths in these 50 largest jurisdictions, but were the cause of 41% of the deaths in all other jails. The suicide rate of the 50 largest jurisdictions (29 per 100,000 was half that of all other jails (57).

- Eight of the top 50 jurisdictions reported no suicides during 2000-02, and another 4 jurisdictions had a suicide rate of 10 per 100,000 or less. Ten of these jurisdictions also had suicide rates of at least 50 per 100,000 inmates, led by Clark County, Nevada (107), Wayne County, Michigan (97), and Baltimore City, Maryland (88).[24]

The smallest jails recorded the highest suicide rates. Indeed, the jail suicide rate rose steadily as jail size decreased and was over 5 times higher (177 per 100,000) in jails with fewer than 50 inmates.[25]

The BJS "Special Report" notes some other interesting characteristics of custodial suicides:

- Males and white inmates had the highest jail suicide rates.

- Jail inmates under age 18 had the highest rate of jail suicides.

- The oldest inmates, age 55 or older, had the highest jail suicide rates among adults.

- White jail inmates were 6 times more likely to commit suicide than Black inmates, and 3 times more likely than Hispanic inmates.

- Black inmates had the lowest suicide rates in state prisons.

- Nearly half of all jail suicides occurred in the first week of custody, while only 7% of all prison suicides occurred during the first month.[26]

A Potpourri of Cases: The Tough News

The Eleventh Circuit Court of Appeals recently provided an accurate and succinct summary of "the law of custodial suicide:"

> "In a prisoner suicide case, to prevail under section 1983 for violation of substantive rights, under….the ….Fourteenth Amendment, the plaintiff must show that the jail official displayed 'deliberate indifference' to the prisoner's taking of his own life." *Cook ex rel. Estate of Tessier v. Sheriff of Monroe County, Fla.*, 402 F.3d 1092, 1115 (11th Cir. 2005) (internal quotation marks and citation omitted). "To establish a defendant's deliberate indifference, the plaintiff has to show that the defendant had (1) subjective knowledge of a risk of serious harm; [and] (2) disregarded….that risk; (3) by conduct that is more than mere negligence." *Id.* (internal quotation marks and citation omitted). "In a prison suicide case, deliberate indifference requires that the defendant deliberately disregard 'a strong likelihood rather than a mere possibility that the self-infliction of harm will occur.' 'The mere opportunity for suicide, without more, is clearly insufficient to impose liability on those charged with the care of prisoners'." *Id.* (citations omitted). An officer "cannot be liable under [section] 1983 for the suicide of a prisoner who never had threatened or attempted suicide and who had never been considered a suicide risk." *Id.* at 1116 (internal quotation marks and citation omitted).[27]

Earlier I obliquely referred to the Eleventh Circuit and *Snow* describing how multiple defendants escaped liability because of inadequate knowledge of the risk of suicide. Officer Chennault, on the other hand, was found to be potentially liable on the following facts and conclusions:

> [A] jury could find that Chennault had subjective knowledge that there was a strong risk that Poiroux would attempt suicide and deliberately did not take any action to prevent that suicide. First, Chennault testified in deposition that he telephoned the Washington County jail, and a jailer told him that, sometime in the last month, Poiroux had tried to cut her wrist while in custody there and had given them a lot of trouble. Second, the Snows [parents] testified that Chennault told them Poiroux was suicidal. Third, it is undisputed that Chennault did not communicate any information regarding his belief that Poiroux was a strong suicide risk to anyone else at the jail. Finally, Chennault stated that he did not take the actions he would have taken had he regarded Poiroux as a suicide risk.
>
> Chennault did not inform Henderson to check on Poiroux every fifteen minutes. Chennault did not remove items from the cells with which Poiroux could have harmed herself. Chennault did not place Poiroux in the drunk tank, and Chennault did not return Poiroux to USA Medical Center for treatment and observation. In short, Chennault did nothing.
>
> That evidence of Chennault's complete failure to take any action after Poiroux was returned to the jail from USA Medical Center creates a substantial issue about whether the suicide of Poiroux was avoidable. Although Henderson testified that she monitored Poiroux fewer than fifteen minutes before Poiroux's suicide, the jury could infer that Henderson and other employees would have been more vigilant had they been informed that Poiroux was suicidal. In addition, a jury could find that, if either Poiroux had been placed in the drunk tank and items she could have used to harm herself removed from her reach or Poiroux had been returned to USA Medical Center, then Poiroux would not have committed suicide.
>
> Although Chennault denies telling the Snows or anyone else that he thought Poiroux was a suicide risk, the conflicting testimony creates an issue of fact for a jury to decide about Chennault's knowledge. Viewing the facts in the light most favorable to Snow, a jury could find that Chennault subjectively believed that there was a strong risk that Poiroux would attempt suicide and deliberately did not take any action to prevent her suicide. Those facts, if found by a jury, would establish a constitutional violation. Because, at the time of Poiroux's death, it was clearly established that an officer's deliberate indifference to the risk of serious harm to a detainee is a violation of the Fourteenth Amendment, the district court erroneously granted summary judgment on Snow's claim against Chennault.[28]

This resembles the custodial suicide perfect storm: Actual knowledge of recent attempts, failure to convey that knowledge to colleagues, and failure to take even reasonably protective or preventive action.

Design

In *Lyche v. Washington Co.*[29] the court upheld the grant of summary judgment to an architecture firm in the face of a claim of design negligence, which allegedly caused a jail suicide. Lyche found a place from which to hang himself about a year after the jail facility was turned over to the County. The court viewed suicide as an intervening cause that precludes liability, relying on the policy basis that a contrary view would expose jail architects to endless liability.[30]

Delay and Deceit

In *Bradich v. City of Chicago*,[31] Judge Frank Easterbrook – who is a pithier version of his former colleague Antonin Scalia — reviewed the pre-suicide events at a police lock-up and found no support for finding deliberate indifference. Decedent was arrested for DUI, his 24th arrest at this lockup, and he was placed in a regular cell. Officers let him keep his regular clothing, failed to obtain medical care, and failed to monitor him.

Within 90 minutes of detention, Bradich had hanged himself while lockup keepers (Easterbrook's term) were playing cards and watching television. Nothing to this point is deemed supportive of deliberate indifference, essentially because chronic arrests and detentions alone and being intoxicated without a prior attempt or recent threat to commit suicide create no special precautionary duty.

My description of pre-suicide events does sound sinister: The dereliction of duty, no special precautionary efforts, and the like. However, there was no alert to a suicide potential, and there was a prior history with decedent suggesting no need for special precautions. That is, being a well-behaved jail regular may be the undoing of the plaintiff's claim.

What happened after Bradich is seen hanging inspired the "delay and deceit" caption. It took three officers an inordinate amount of time even to open the cell door, Bradich appearing to be alive at this point, and then more time to obtain a knife from the kitchen to cut him down.

Only one officer had CPR training and he inexplicably kept slapping Bradich instead of using CPR. Ten minutes after the discovery an ambulance was called and dispatched, arriving some nine minutes later with EMT staff finding Bradich dead.

Easterbrook finds it credible to believe that during the period of delay the officers altered the logbooks and disguised the cell to cover up their errors. Bradich was found with three t-shirts, two of which were used as the ligature. There is no obvious answer, but serious questions, to why all this clothing was in the cell.

With characteristic understatement, Judge Easterbrook notes, "Protecting one's employment interests while an inmate chokes to death would exemplify "deliberate indifference to serious medical needs."[32] Indeed! Might even be manslaughter.

Summary judgment in favor of defendants was reversed. What could the Federal District Court have been thinking of when ruling for the defendants?

It is perhaps redundant at this point to suggest that this is about as bad as it gets for post-suicide attempt conduct. Regrettably,

altering the logs is not such unusual behavior as to have rendered me breathless.[33]

To Screen or Not

Screening develops information and while information may not set you free, it may allow you to do something – like protect a detainee or preserve a life — that you might not otherwise do. Information is the twin brother (or sister) of knowledge, as in the deliberate indifference requirement of actual knowledge. Neither information or knowledge is necessarily related to wisdom — an ability to discern — which the Constitution wisely does not appear to require.

Parenthetically, while screening is plainly a definable process, screening may have a variety of objectives including medical, mental health, and suicide risk which very often is handled as a part of mental health screening. In this brief section, we look at suicide screening through the lens of *Gray v. City of Detroit*.[34] Circuit Judge Merritt wrote:

> Suicide is a difficult event to predict and prevent and often occurs without warning. Both the common law and the recently developed constitutional law applying to those in custody have taken this uncertainty into account in developing rules of liability based on foreseeability. In *Barber v. City of Salem*, this Court held that: "the proper inquiry concerning the liability of a City and its employees in both their official and individual capacities under section 1983 for a jail detainee's suicide is: whether the decedent showed a strong likelihood that he would attempt to take his own life in such a manner that failure to take adequate precautions amounted to deliberate indifference to the decedent's serious medical needs." 953 F.2d 232, 239-40 (6th Cir. 1992) (adopting the holding of *Popham v. City of Talladega*, 908 F.2d 1561, 1563-64 (11th Cir. 1990)). *Barber* confirmed an earlier holding that there is no general constitutional right of detainees to receive suicide screenings or to be placed in suicide safe facilities, unless the detainee has somehow demonstrated a strong likelihood of committing suicide. See *Danese v. Asman*, 875 F.2d 1239, 1244 (6th Cir. 1989); *Crocker v. County of Macomb*, 119 Fed. Appx. 718, 2005 U.S. App. LEXIS 127, No. 03-2423, 2005 WL 19473, at *5 (6th Cir. Jan. 4, 2005) (unpublished) (finding no change in the law since *Danese* was decided in 1989). As one commentator put it, "[a] right to screening for suicidal propensities or tendencies arises when it is *obvious* that an inmate has such tendency or propensity" (emphasis added) — in other words, when the suicide is clearly foreseeable. George J. Franks, *The Conundrum of Federal Jail Suicide Case Law Under Section 1983 and Its Double Bind for Jail Administrators*, 17 Law & Psychol. Rev. 117, 125 (1993).

Thus, at least for the Sixth Circuit, there is no generalized right to suicide screening unless, in my words, it is not needed. Screening is detection with a course of action, including a more professional evaluation, dictated by a positive screen.

Gray was known to be "mental" by one arresting officer. When he was placed in a special holding cell he started ranting and destroying the cell. Gray was removed to a hospital for medical care where he hung himself with a hospital gown in a hospital holding cell.

Gray's complaints and conduct, writes Judge Merritt, were physical in nature showing no strong likelihood he was a suicide risk.[35] Only if each individual officer's knowledge and opinion is stitched together is there a possible case for "actual knowledge." Deliberate Indifference, finds the court, does not rest on collective knowledge.[36]

Post-Suicide Issues

A Model Suicide Prevention Policy speaks clearly to what should be done when correctional staff enters an area where there is an obvious suicide attempt:

> Upon entering the cell, correctional staff shall never presume that the victim is dead, rather life-saving measures shall be initiated immediately. In hanging attempts, the victim shall first be released from the ligature (using the emergency rescue tool if necessary). Staff shall assume a neck/spinal cord injury and carefully place the victim on the floor. Should the victim lack vital signs, CPR shall be initiated immediately. All life-saving measures shall be continued by correctional staff until relieved by medical personnel.[37]

Model rules or best practices, however, do not always coincide with the relevant legal rules. *Dipace v. Goord*[38] dealt with the question of when it may be deliberate indifference to fail to make any effort to revive a prison inmate found hanging in his cell. The Federal District Court adopted the Magistrate Judge's report, which found that as of August 1999 the law on point was not defined with reasonable clarity thus requiring a finding of qualified immunity on behalf of two officers

UPDATE
ON THE INTERNET

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

www.ncianet.org/cjjsl.cfm

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

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

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

and a nurse. Qualified immunity serves as a defense where the constitutional right at issue was not clearly defined at the time of the event at issue. The court also suggested that in the interim the law has changed putting more of an affirmative duty on responding staff to attempt revival where there is no danger to staff and the stricken inmate just might benefit. Thus, current law may actually coincide with the Model rule noted earlier.

Ralph Tortorici had a long history of mental illness known to the New York State Department of Correctional Services. (DOCS). He was last seen alive in his cell at 4:32am on August 10, 1999. Correctional Officer Krause found decedent hanging from a sheet in his cell at 4:47am. Krause radioed for help and entered the cell pulling the looped sheet from Tortorici and lowering him to the ground.

Correctional Officer Skinner arrived and found no pulse or vital signs. Nurse Murphy then arrived and found no radial or carotic pulse. She used a stethoscope and heard no heart beat. She also noted signs of lividity. None of the above individuals started any resuscitation efforts, although a DOCS policy required immediate CPR for "any person found unresponsive and without pulse or respirations."

1. Correctional Officer Krause

As it developed, Krause's radio was not working when he attempted to make the "code blue" call and he ran about 150 feet to the control room to get the cell door opened. He returned to the cell in about 30 seconds. He clearly believed on first contact that the inmate was dead. He heard sounds indicating others, likely more trained, were on the way. The court found:

> In light of recent case law, it would be reasonable to conclude today that prison officials have a duty to administer life-saving care even in the absence of a pulse or respiration where circumstances indicate the possibility of a very recent death and the individuals are available to give such care. Given the expected imminent arrival of medical personnel, however, it might not be the case that the Constitution imposes that obligation on an individual officer under the circumstances in which CO Krause found himself.
>
> In any event, it is plain that any such right was not clearly established in 1999 because the law in this area was not "defined with reasonable clarity."[39]

Other courts of this era appear to have accepted that a good faith belief that an inmate already was dead excused efforts to revive. At the worst, it might be negligence. Thus, Krause's reasonable belief that death had occurred and that more trained help was on the way established his claim to immunity.

2. Correctional Officer Skinner

Correctional Officer Skinner was in about the same legal situation. He checked for pulse and respiration and found neither. He did write a mildly contradictory note, "I think I felt a pulse, but I'm not sure." However, there was no evidence that the inmate was alive or could have been saved. Skinner now cannot recall even creating the note. Thus, with only this note to rely on the case could not even go to a jury on deliberate indifference.

3. Nurse Murphy

As was true for Krause and Skinner, the only evidence in the record was that Nurse Murphy believed that Tortorici was dead based on her evaluation of him. Perhaps as a predicate for the belief Nurse Murphy harbored ill will towards inmates, plaintiffs argued that Murphy had a personal policy against administering CPR to prisoners. However, the deposition testimony plaintiffs relied on for this predicate demonstrated that Nurse Murphy had a policy of not performing mouth-to-mouth resuscitation to inmates due to the risk of disease; she clearly stated that she performed CPR on inmates with the aid of an "ambu-bag."

Plaintiffs argued that Nurse Murphy violated a DOCS directive in failing to commence CPR. The policy required "First Responders" to "immediately" commence CPR on 'any person found unresponsive and without pulse or respirations.' The violation of this state policy, finds the court, does not provide a basis for finding that there was a violation of the Federal Constitution.

In summing up, the court states:

> Taking all evidence in their favor, plaintiffs at best have made the case that Nurse Murphy was faced with a body without pulse or respiration — but one that theoretically might still have benefited from a resuscitation effort, such as CPR. And, as the court previously noted with respect to CO Krause, the court would be prepared to hold that a trained prison employee's failure to commence such efforts where there is no danger to the employee — and when faced with a person who might benefit from such efforts — constituted a violation of the Eighth Amendment's "deliberate indifference" standard (although it is unclear that plaintiffs have mustered enough evidence to show that Tortorici might have benefited from resuscitation efforts by the time Nurse Murphy arrived). Such a ruling, however, would be of no assistance to plaintiffs for the same reasons already stated as to CO Krause: case law existing in 1999 disagreed with this premise and declares that the failure to conduct CPR does not constitute a constitutional violation. Because of the lack of clarity in the law at that time, Nurse Murphy is entitled to qualified immunity from suit.[40]

Obviously, today it is the far better practice to follow the Model Policy provision set out earlier in the text. Do not confuse what might seem to be a vain act with what is now almost certainly a legally required act.[41]

Conclusion

Liability for custodial suicide, whether a prisoner, detainee, or arrestee, in a Section 1983, Federal Civil Rights Action, remains very difficult to establish. Establishing actual knowledge of a high degree of risk is difficult except in the most obvious and egregious cases.

Cases are settled; without doubt, and then do not find their way into the collective body of wisdom found in our reported case law. Those cases likely will be the most egregious and difficult to defend. In repeatedly making my "it's difficult to win" statement, I

hope I do not provide custodians with a false sense of security or a dubious sense of what's right. The indefensible case that is settled, then, may more nearly resemble the case to avoid than the cases discussed here.

Aside from Section 1983 litigation, some plaintiffs elect to sue under the Federal Tort Claims Act (FTCA), 28 U.S.C.A. §2875, passed first in 1946. The FTCA requires that the entity sued be a federal agency; government employees are exempt from liability; and state law is the basis for ordinary, substantive tort law.

In *Jutzi-Johnson v. United States*,[42] Judge Posner, for the court, reversed an award of $1.8 million for a jail suicide where defendants conceded negligence — deliberate indifference is not required — but ultimately prevailed on lack of causation.

The federal detainee acted very strangely and scratched himself to the point where his body was covered with open sores. The causation issue relates to decedent actually hanging himself v. scratching himself to death. Thus, one may infer that even where there may be a risk of suicide, the means of death should be within the ambit of that risk.

Again, this is an often depressing, legally confusing, and complex area.

Dr. James Knoll, a leading correctional psychiatrist states that suicide prevention begins at arrest; police play a critical role in observing and communicating relevant information about an arrestee's behavior to lockup staff.[43] He is, of course, absolutely correct.

Beyond this, Lindsay Hayes' recommendations on the key to prevention are as good as they get including: staff training, identification/screening, close attention to inmates in segregation, suicide resistant housing, clarity on when to require various levels of observation, emergency intervention training and strategies, and mortality reviews.[44]

Footnotes

[1]511 U.S. 825.

[2]James E. Robertson (2004), "The Impact of *Farmer v. Brennan* on Jailers' Personal Liability for Custodial Suicide: Ten Years On," Jail Suicide/Mental Health Update, 13 (1): 1-5.

[3]*Snow v. City of Citronelle*, 420 F.3d 1262, 1269 (11th Cir. 2005), discusses various jail-employee defendants who were exonerated while finding one employee possibly with subjective knowledge that there was a strong risk the detainee would commit suicide and who took no preventive action.

[4]Depositions, of course, are a rough equivalent with a defendant simply saying, "I didn't know" or "I didn't know he was serious."

[5]Where a psychologist told a Wisconsin Supermax inmate, "No one will care if you die!," this was held to not be evidence of deliberate indifference: *Means v. Cullen*, 297 F.Supp.2d 1148 (W.D. Wisc. 2003). On the other hand, it is also not evidence of a caring clinician.

[6]Robertson, note 2 at 5.

[7]*Taylor v. Wausau Underwriters Insurance Co*., 423 F.Supp.2d 882 (E. D. Wisc. 2006).

[8]Fred Cohen (1998), *The Mentally Disordered Inmate And The Law*, 14.5.

[9]2001 WL 506863 (N.D. Ill.)(*Woodard I*) and *Woodard v. Myres*, 2002 WL 31744663 (N.D. Ill.)(*Woodard II*).

[10]Numbering supplied for clarity; the actual form has blank lines for the writer to mark with an "X" or check.

[11]See *Estate of Max G. Cole v. Fromm*, 941 F.Supp.776 (S.D. Ind. 1995) *aff'd*, 94 F.3d 254 (7th Cir. 1996). The detainee committed suicide with a plastic liner used in a clothes hamper, and the court found suicide in this fashion to be a "mere possibility." Thus, suicide was believed possible but not in this fashion.

[12]2002 WL 31744663 at 12.

[13]See *City of Canton v. Harris*, 489 U.S. 378 (1989), municipal liability here cannot be vicarious, it must rest on direct involvement or a policy and/or practice linking the entity to the proscribed result.

[14]In *Cunningham v. Lake Co. Correctional Technician Erica Sandahl et al* 1998 WL 157415 (N.D. Ill.), CMS settled for an undisclosed sum where an employee failed to make a referral after intake screening showed an imminent risk of suicide. Discussed in Fred Cohen (2003), *The Mentally Disordered Inmate And The Law*, Cum. Supp. S14-2, 3. This, of course, is the same jail as in the instant case.

[15]*Domino v. Texas Dept. of Criminal Justice*, 239 F.3d 752 (5th Cir. 2001).

[16]See e.g., *Myers v. County of Lake*, 30 F.3d 847 (7th Cir. 1994).

[17]See *Cunningham v. Sandahl*, 1998 WL 157415 (N.D. Ill)(Unpublished). Source: *Prison Legal News* (November 2003).

[18]2002 WL 1465908 (D. Me.)

[19]For a complete discussion of the facts, see *Pelletier v. Magnusson*, 195 F.Supp.2d 214 (D. Me. 2002).

[20]Christopher J. Mumola (2005), *Special Report: Suicide and Homicide in State Prisons and Local Jails*, Bureau of Justice Statistics (Hereafter, *Special Report*). To implement the Death in Custody Reporting Act of 2000 (42 USCA § 13701), BJS began collecting inmate death records from jails in 2000 and state prisons in 2001.

[21]*Ibid*. According to one source, suicide levels have decreased 38% in the federal system since 1990. Karen L. Cropsey (2003), "Suicide in Jails and Prisons: What the Numbers Tell Us," *Univ. of Dist. Col. L. Rev*., 7 (213): 214. The author attributes this data to a telephone call to an unnamed Federal Bureau of Prisons staff person.

[22]Suicides in correctional facilities in Great Britain have doubled since 1983 and are eight times the suicide rate in America's prisons.

[23]*Special Report*, p. 3.

[24]*Special Report*, p. 4.

[25]*Special Report*, p. 5. Given the small overall populations, however, small jails (populations of 50 or less) accounted for only 14% of all jail suicides.

[26]*Special Report*, pp. 3-9. In the past, the shared belief was that the risk of jail suicide was highest in the first 24 hours with the hours of 10:00pm to 2:00am, considered the riskiest time of day.

[27]*Snow v. City of Citronelle*, 420 F.3d 1262, 1268-69 (11th Cir. 2005). It would not be inaccurate, merely superficial, to characterize the Eleventh Circuit summary in the text as a current primer on constitutionally grounded, custodial suicide.

[28]420 F.3d at 1270-71.

[29]2006 WL 680206 (9th Cir.) (Slip Copy). See Lindsay M. Hayes (2003), "Suicide Prevention and 'Protrusion-Free.' Design of Correctional Facilities," *Jail Suicide/Mental Health Update*, 12 (3), for a discussion of the Washington County Jail and a case from Nassau County, New York, where the parties settled for $875,000 in a case involving a known suicidal inmate who hung himself on a clothing hook previously used in two other suicides.

[30]But see *Jackson v. City of Detroit*, 537 N.W.2d 151 (Mich. 1995), denying summary judgment where there was evidence that the City knew that overhead bars in the cells were a significant self-injury risk to suicidal inmates and there had been 128 attempted suicides over the previous 5 years. Design hazard cases, as in *Jackson*, where the jailer is sued, are distinguishable, of course, from suing the designer. Design hazard cases nearly always result in victories for the defendants.

[31]413 F.3d 688.

[32]413 F.3d at 691.

[33]See *Dipace v. Goord*, 308 F.Supp.2d 274 (S.D.N.Y. 2004), suggesting that it may now be unconstitutional to fail to make an effort to revive even if an apparent suicide appears lifeless. In *Sisk v. Manzanares*, 270 F.Supp.2d 1265 (D. Kan 2003), there was testimony that it was a

regular practice to leave blank spaces in a suicide watch log and then go back and fill them in, although, not necessarily falsely except as to the time.

[34]399 F.3d 612 (6th Cir. 2005).

[35]In *Taylor v. Wausau Underwriters Insurance Co*., 423 F.Supp.2d 882, 889 (E.D. Wis. 2006), the judge correctly concluded that the absence of mental illness is not fatal to a custodial suicide claim. The danger signals were the heinous nature of the crime and decedent having been a correctional officer.

[36]It is also interesting to note that Judge Merritt's summary of the law of custodial suicide could have been written before *Farmer v. Brennan* finding no change since at least 1989. See also *Cruise v. Marion*, 404 F.Supp.2d 656 (M.D. Pa. 2005), where an intoxicated detainee hung herself after an unsuccessful effort to perform an intake and where plaintiffs failed to show deliberate indifference as to alleged lack of training and inability to detect suicide risks.

[37]Lindsay M. Hayes (2005), "A Practitioner's Guide to Developing and Maintaining a Sound Suicide Prevention Policy," *Jail Suicide/Mental Health Update*, 13 (4): 12. Other "Model" sections address emergency response equipment, notification procedures, and appropriate procedures depending on the security level of the housing unit.

[38]308 F.Supp.2d 274 (S.D.N.Y. 2004).

[39]308 F.Supp.2d at 284.

[40]308 F.Supp.2d at 288.

[41]The court reviews a number of interesting decisions on point, which we reproduce as an aid to possible further research: *Heflin v. Stewart County*, 958 F.2d 709 (6th Cir.), cert. denied, 506 U.S. 998 (1992); *Clinton v. County of York*, 893 F. Supp. 581(D.S.C. 1995); *Reed v. Woodruff County*, 7 F.3d 808 (8th Cir. 1993); *Jackson v. Johnson*, 118 F. Supp. 2d 278 (N.D.N.Y. 2000), appeal dismissed in relevant part, 13 Fed. Appx. 51, (2d Cir. June 27, 2001); *Tlamka v. Serrell*, 244 F.3d 628 (8th Cir. 2001); *Bahner v. Carmack*, 1997 WL 94705 (8th Cir. Mar. 6, 1997). In *Bradich v. City of Chicago*, 413 F.3d 688 (7th Cir 2005), dealt with earlier as "delay and deceit," there were futile efforts at resuscitation, unacceptable delay in getting medical help, and a likely cover-up of pre- and post-suicide events.

[42]263 F.3d 753 (7th Cir. 2001).

[43]See Eve Bender (2004), "Averting Prison Suicides Requires Special Strategies," *Psychiatric News*, 39 (15), for a discussion about an AAPL conference panel in which I participated.

[44]Excerpted from a Report prepared for the Ohio Department of Rehabilitation and Correction (Nov. 19, 2004). Report on file with author. ❑

Inmate Suicide Case Law in the Federal Courts (2003 to the Present)

Offered below is a comprehensive listing of all inmate suicide case law from the federal courts, as published in either West's Federal Supplement or Federal Reporter from 2003 to the present. (Cited cases between 2000 and 2004 can be found in the Jail Suicide/Mental Health Update, Volume13, Number 1, Summer 2004, pages 6-8.)

2003

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

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

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

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

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

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

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

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

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

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

$252,000 because state statutory limit on wrongful death awards.)

2004

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

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

Kelley v. County of Wayne, 325 F. Supp. 2d 788 (E.D. MI. 2004)
(Summary judgment to defendants; not foreseeable that decedent's heroin withdrawal would lead to suicide)

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

Stewart v. Waldo County, 350 F. Supp. 2d 215 (D. ME. 2004)
(Summary judgment to defendants; despite intoxication, no indication that decedent was at risk for suicide)

Turney v. Waterbury, 375 F.3d 756 (8th Cir. 2004)
(Summary judgment affirmed for all defendants, except sheriff, because their conduct was negligent at best; sheriff's knowledge of inmate's suicide risk, which included not investigating an earlier suicide attempt, not permitting an officer to complete the inmate's intake form, placing the inmate in a cell alone with a bed sheet and exposed ceiling bars, and ordering the jail's lone officer not to enter the inmate's cell without backup were facts which a jury could find exhibit deliberate indifference)

Wever v. Lincoln County, 388 F.3d 601 (8th Cir. 2004)
(Qualified immunity to sheriff denied; county jail failed to have written suicide prevention policy or training; "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)

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

2005

Abdollahi v. County of Sacramento, 405 F. Supp.2d 1194 (E.D. CA. 2005)
(Consolidated lawsuit involving three inmate suicides; summary judgment to defendants in two cases in which there was no evidence that deficient cell check policy and understaffing contributed to those deaths; plaintiff presented evidence in one case that county's suicide prevention policy was deficient; evidence that a jury could find sheriff, captain, an officer, and selective mental health personnel were deliberately indifferent in one or more of the cases)

Bradich v. City of Chicago, 413 F.3d 688 (7th Cir. 2005)
(No indication that decedent was a known risk for suicide, however, deliberate indifference could occur if jail staff unnecessarily delayed (up to 10 minutes) emergency medical response, including cardiopulmonary resuscitation — "Protecting one's employment interests while an inmate chokes to death would exemplify deliberate indifference to serious medical needs")

Cook v. Sheriff of Monroe County, 402 F.3d 1092 (11th Cir. 2005)
(Summary judgment to defendants is affirmed; staff did not have actual knowledge that decedent was at risk for suicide; district court exercised its discretion in excluding evidence of other suicides and plaintiff's expert)

Cruise v. Marino, 404 F. Supp. 2d 656 (M.D. PA. 2005)
(Plaintiffs failed to show deliberate indifference as to alleged lack of training and inability to detect suicide risk of intoxicated detainee)

Gaston v. Ploeger, 399 F. Supp. 2d 1211 (D. KS. 2005)
(Sufficient evidence for a jury to conclude that decedent was a known risk for suicide and that sheriff, sergeant, and an officer failed to take adequate steps to prevent the death)

Gray v. City of Detroit, 399 F.3d 612 (6th Cir. 2005)
(Summary judgment to defendants is affirmed; staff did not have actual knowledge that decedent was at risk for suicide)

Harvey v. County of Ward, 352 F. Supp. 2d 1003 (D. N.D. 2005)
(Summary judgment to sheriff and jail administrator, who were not aware of decedent's suicide risk; evidence that suicide prevention policies and training were allegedly deficient did not rise to deliberate indifference)

Keehner v. Dunn, 409 F. Supp. 2d 1266 (D. KS. 2005)
(Summary judgment to defendants; jail staff did not have actual knowledge that decedent was at high risk for suicide)

Mann v. Lopez, 404 F. Supp. 2d 932 (W.D. TX 2005)
(Consolidated lawsuit involving two inmate suicides; summary judgment granted to sheriff in his individual capacity due to qualified immunity; no indication that sheriff was aware that the decedents were at risk for suicide)

Martin v. Somerset County, 387 F. Supp. 2d 65 (D. ME. 2005)
(Summary judgment to sheriff and county; but summary judgment denied to supervisor and officer who failed to adequately observe suicidal inmate)

Perez v. Oakland County, 380 F. Supp. 2d 830 (E.D. MI. 2005)
(Summary judgment to defendants; although a caseworker's decisions in the case were questionable, they were not violative of existing law)

Snow v. City of Citronelle, 420 F.3d 1262 (11th Cir. 2005)
(Summary judgment to all but one defendant; genuine issue existed that jail officer had knowledge of decedent's suicidal risk and failed to communicate that risk or take steps to prevent suicide)

Woloszyn v. County of Lawrence, 396 F. 3d 314 (3rd Cir. 2005)
(Summary judgment to defendants affirmed; jail staff did not have actual knowledge that decedent was at high risk for suicide)

2006

Drake v. Koss, 445 F.3rd 1038 (8th Cir. 2006)
(Summary judgment to defendants where jailers, acting on recommendations of psychiatrist who viewed inmate as manipulative, did not view detainee as suicidal and, therefore, were not deliberately indifferent)

Posey v. Southwestern Bell Telephone, 430 F. Supp. 2d 616 (N.D. TX. 2006)
(Summary judgment to defendants; jail staff's failure to remove corded telephones after being ordered to do so, and their failure to follow the suicide risk screening policy, are acts of negligence and possibly gross negligence, but not deliberate indifference)

Short v. Smoot, 436 F. 3d 422 (4th Cir. 2006)
(Summary judgment to all defendants except one officer who observed decedent attempting suicide via closed circuit television monitor and failed to intervene and prevent the suicide)

Taylor v. Wausau Underwriters, 423 F. Supp. 2d 882 (E.D. WI. 2006)
(Deliberate indifference to a substantial risk of suicide, even absent mental illness, constitutes deliberate indifference; summary judgment to defendants; although decedent was on suicide precautions based solely upon nature of charges and former employment as a correctional officer, he was not viewed as a substantial risk for suicide requiring further precautions against self-harm) ❑

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.

Illinois

Inmates at the Peoria County Jail who have mental illness are finally receiving the care they need, thanks to a federal grant recently secured by the governor. On April 18, 2006, Governor Rod Blagojevich announced $375,000 will be disbursed to jails in Peoria, Will and Jefferson counties to start a program called Jail Data Link. The three counties were picked because of their geographic location and large number of inmates detained at each jail.

The program, which was started in the late 1990s in Cook County and has been a success, is a computer database that cross-references the daily census of correctional facilities with mental health centers in the state. The database allows recipients of mental health services who are arrested or detained to continue receiving care, and to connect them with services before they are released.

Steve Smith, superintendent of the Peoria County Jail, told the *Peoria Journal Star* that the program was initiated in his facility in January 2006 after a counselor was contracted from the Human Service Center by the state Department of Human Services. The counselor is a salaried, full-time employee who is paid by the Human Service Center. "On a daily basis there is a crosscheck of the jail roster to a list of clients who have previously had services with the Illinois Department of Human Services," Superintendent Smith said. "When there is a hit or match, the local jail is notified and then the counselor on site begins treatment or linkage services." The counselor is responsible for linking detainees with community health providers to obtain appropriate services, including medication and other treatments, and help them towards recovery. "He (the counselor) can also be available to do screening of other individuals that jail staff have identified may need assistance," the superintendent told the *Peoria Journal Star.* It was estimated at least 10 percent of the Peoria County Jail population would benefit from the new program.

Alabama

In June 2006, Baldwin County Jail officials temporarily stopped using restraint rails and launched an investigation of jail policies and procedures after an inmate was found dead while handcuffed to a rail in the holding cell. According to Lieutenant John Murphy, spokesman for the Baldwin County Sheriff's Office, 45-year-old Ross Paul Yates was booked into the jail on a third-degree burglary charge on May 27 and moved to the holding cell at approximately 10:30pm on May 30 following concern that he "suffered from diminished mental capacity." Lt. Murphy told the *Mobile Press-Register* that Mr. Yates "aggressively" kicked the cell door, raising concern that he might hurt himself. The inmate was found unresponsive approximately three hours later, he said.

According to Baldwin County Coroner Huey Mack Sr., however, rigor mortis had set in before Mr. Yates was pronounced dead at 1:30 am on the morning of May 31, suggesting that it takes at least four hours for the stiffening of the body to occur. "I can't help but believe that something is not correct," Mr. Mack said, adding that he was unsure what led to the death. "He had probably been dead for several hours, just hanging on the wall." A subsequent autopsy performed by the state Department of Forensic Sciences was

inconclusive, and the medical examiner was awaiting further tests, including a toxicology report. The Alabama Bureau of Investigation is also looking into Mr. Yates' death.

Baldwin County Sheriff's Office Chief Deputy Larry Milstid told the *Mobile Press-Register* that an unnamed correctional officer was monitoring Mr. Yates' holding cell, but it was unclear how often the officer checked on the inmate. The officer has since been reassigned to another section of the jail. It was also not known whether Mr. Yates was ever assessed by mental health personnel.

Inmates handcuffed to the restraint rails should be checked on every 30 minutes, according to a copy of recommended jail procedures provided by the Southern Center for Human Rights, a nonprofit public interest law firm in Atlanta. Sarah Geraghty, a lawyer with the center, told the *Mobile Press-Register* she had been investigating complaints about the restraining technique at the Baldwin County Jail for about a year. At the time of the incident, jail staff were using a "D-Ring," a device that forces inmates to stand, handcuffed to a metal ring or rail inside a cell, with their hands behind their backs for up to eight hours. "There seems to have been a pattern of leaving inmates on the rail for long periods of time without checking," she said before concluding that "there are better ways to deal with unruly inmates."

As a *Mobile Press-Register* editorial concluded on June 3, "The quick removal of the so-far unidentified corrections officer from responsibility for checking restrained prisoners was a welcomed step. And authorities also were right to call in the Alabama Bureau of Investigation to find out more about how and why Mr. Yates died. Incarceration in the Baldwin County Jail shouldn't be a death sentence for anyone. Once the ABI investigation is complete, jail officials can revise their policies and procedures to ensure that everything possible is done to see that it isn't."

Delaware

A 56-year-old Hockessin man hanged himself last month hours after he was taken off a suicide watch by the Department of Correction — and despite warnings from family and mental health advocates of a recent suicide attempt. At 4:52 am on May 30, prison officers found Thomas J. Burns hanging from a bedsheet in his cell. Burns had arrived at Young Correctional Institution on a forgery warrant. Only days before the prison suicide, Burns was released from Christiana Hospital, where he nearly died after trying to kill himself by mixing medication and liquor. Mental health advocates flooded the prison with phone calls, trying to alert the jailers that Burns would try to kill himself in the prison.

Prison officials initially placed Burns on suicide watch — a restrictive status involving constant surveillance during which Burns was allowed only a paper gown in his cell. But on Memorial Day, a counselor employed by the prison's private medical contractor, Correctional Medical Services, conducted a mental health evaluation and ordered Burns placed on the less-restrictive psychiatric observation. Burns was given several personal items — including bed sheets — and guards were supposed to check on him every 15 minutes. Hours later, he was dead.

Suicide is the third-leading cause of death in prisons nationally — behind natural causes and AIDS-related deaths, which are recorded separately from natural causes by the U.S. Bureau of Justice Statistics. According to the bureau's latest report, issued last month, Delaware's prisoner suicide rate for 2001 and 2002 was double the national average of 14 per 100,000 inmates.

The quality of medical and mental health services inside Delaware prisons is central to an ongoing investigation of the Delaware Department of Correction by a special civil rights team from the U.S. Justice Department. High rates of inmate deaths from HIV/AIDS, mistreatment of cancerous tumors and the spread of flesh-eating bacteria are just some of the factors attracting federal scrutiny.

Burns' death will be reviewed internally, said Correction Commissioner Stan Taylor, and the findings will be closed to the public. Burns' suicide is similar to previous deaths in Delaware prisons.

As he was booked into Howard Young (then called Gander Hill prison) in 2004, Christopher Barkes told a mental health screener that he had attempted suicide before — when he had earlier served time in Gander Hill. Barkes provided a list of drugs he was taking for depression, post-traumatic stress disorder and other forms of mental illness. Instead of placing Barkes on suicide watch, prison officials put him in a cell, alone and unsupervised. Hours later, Barkes hanged himself with a bedsheet. His widow, Karen, has sued the state over the death. "It is very disturbing that after Chris's suicide, they still aren't going to change anything," she said. "Chris died and nothing changes."

According to the Department of Correction, 11 inmates have killed themselves since January 2000 — most by hanging.

Experts say effective mental health care can reduce the number of suicides in the state's nine prison facilities. In Delaware, Correctional Medical Services provides medical and mental health treatment.

When an inmate arrives in prison, these CMS counselors use a form that has a series of yes/no questions to determine suicide risk. If the risk of suicide is high, they may require the inmate to sign a "suicide contract" promising not to kill themselves. Mental health experts have described these practices as antiquated and ineffective.

Level of Expertise

Neither prison nor Correctional Medical Services officials would name the counselor who evaluated Burns. They described the counselor as a "master's-level clinician."

"You do not evaluate a person for suicide without a psychiatrist," said Rita Marocco, executive director of the National Alliance for the Mentally Ill in Delaware. "If a person has made a suicide attempt, it certainly must be a psychiatrist who makes the decisions. I believe they do not have qualified people doing these evaluations."

Dr. Carol A. Tavani, a board-certified neuropsychiatrist and executive director of Christiana Psychiatric Services, agrees that a psychiatrist — not a counselor — should have conducted the evaluation. "When you have something of this seriousness, with this kind of history, especially when there's a prior attempt, that ratchets up the seriousness of the risk," Tavani said. "Evaluation of suicidality has to be done very carefully, and it's always the better part of valor to err on the safe side, particularly if there's

previous history. Those calls are always safest when made by a psychiatrist, and I know they do have them."

Patricia McDowell, Delaware's director of support and outreach services for the National Alliance for the Mentally Ill, told prison officials about Burns' recent suicide attempt and warned them he would try it again. After Burns' death, these officials stopped taking her calls. "We worked very carefully to get to the right people, to help someone at a very critical point in his life, and the very people we turned to let us down," McDowell said. "The system failed. His life ended."

Jeremy McEntire is the treatment administrator for the Delaware Department of Correction. "I am definitely sorry about what happened, and I know the commissioner is as well," he said. When first asked about the case by a reporter, Taylor said "the system did not fail" Burns.

The prison was not aware of Burns' suicide attempt, Taylor said. "That information was not available at that point in time." But when told that Marocco and McDowell had insisted they warned prison administrators of Burns' recent attempt, Taylor's story changed. "I believe the info we had received from NAMI was that he had just gotten out for a recent suicide attempt," he said.

Citing patient confidentiality concerns, Correctional Medical Services spokesman Ken Fields declined to address questions surrounding Burns' suicide. Fields did say that master's-level clinicians spend a great deal of time working with patients who have mental health needs and are well-suited to participate in the evaluation of mental health needs and the suicide risk of patients. "They receive extensive training on suicide prevention and risk assessment," he said.

Delaware State Police spokeswoman Sgt. Melissa Zebley said her agency was asked to investigate Burns' suicide — a standard practice for inmate suicides or any suspicious prison death. Zebley said the Medical Examiner's Office determined Burns had hanged himself and the case is closed. Zebley said she was not permitted to name the counselor who removed Burns from suicide watch, or describe his or her level of education and licensure status.

History

Burns graduated from the Delaware Law School of Widener University (now Widener School of Law) in 1983 but never took the bar exam or practiced law. "Because of his mental illness, he was never able to live up to his capacity," said Burns' ex-wife, Marjorie Lamb. Despite obvious signs, Burns never sought treatment or a diagnosis.

Barry MacMonegle was a University of Delaware student when he met Burns. "He was a relatively attractive, well-mannered, well-educated individual and he was always willing to talk with people about their problems," MacMonegle said. And people always wanted to talk to him, particularly about their legal problems, everything from parking violations to tenant disputes.

Burns and Lamb have three children: Alexander Burns and twins Jessica and Robert Burns. Before they divorced after nine years of marriage, Burns helped run Lamb's family business in Hockessin, Lavender Hill Herb Farms.

Because of his education, many thought he was lazy. He also started becoming anti-social. "As far as his relationship with me, over time I realized that his behavior stemmed from mental illness," Lamb said. "I tried to ask him about it. He just avoided answering. I don't know that anyone else confronted him about it. Everyone else just viewed his behavior as aggressive."

After the divorce, Burns turned to MacMonegle. At the time, MacMonegle was running a small business and offered him a part-time job bookkeeping. MacMonegle eventually let Burns go.

Forgery

In early 2000, Burns began filing lawsuits in state and federal court against Lamb, her business, her family and lawyers he claimed to have hired for his divorce. In his suits, he often made up facts, such as having started his wife's business and alleging misconduct by his divorce lawyers. "He was very nice with the children, and came across normally to most people, but his mental illness manifested itself in a lot of lawsuits," Lamb said. "When they first started, I thought they were attacks on me personally. I didn't realize how bad his mental state had gotten."

These embellishments got him in legal trouble in 2004, when Burns forged documents suggesting that Family Court Judge Jay H. Conner had a business relationship with Lamb. Burns then presented the forgeries to Conner. Conner was the presiding judge in the couple's divorce and settlement case and Burns wanted him removed. Burns was convicted in January of several forgery charges and was to be sentenced last month. When he failed to show up for sentencing, a warrant was issued for his arrest. Lamb knew the forgeries were cries for help. "I kept telling the prosecutor to look at what he was filing," she said. "They were really out there."

Knowing they were coming for him, MacMonegle said, Burns tried to commit suicide by taking pills and alcohol. Police, who found him at his sister's Hockessin house, had him rushed to Christiana Hospital. Shortly before Burns was released from Christiana Hospital, Burns' sister told police where they could pick up her brother for the felony warrants. "She wanted to grab this opportunity to get her brother evaluated," McDowell said.

The suicide that followed his incarceration was all too predictable, Marocco said. She relayed these concerns to a female shift commander at the prison. "I told her that his family was concerned that if he's in prison, he could become suicidal, because he was confronted with a reality that he has managed not to face," she said.

No Accountability

The federal civil rights investigation into Delaware prisons, launched in March, could take years. The probe came on the heels of a five-month preliminary inquiry by the Justice Department during which federal regulators interviewed the same medical experts, inmates and families of dead inmates who spoke to *The News Journal* late last year during the newspaper's six-month investigation of prison health care.

McEntire wouldn't say whether the investigations, articles and probes have led to a heightened sensitivity toward medical and

mental health issues within the Department of Correction. "I'd rather not comment about that," he said.

McEntire and Taylor pointed out that Burns' death will be investigated by the Department of Correction's Mortality and Morbidity Review Committee — a panel consisting of the prison warden, Correctional Medical Services staffers and the Medical Society of Delaware. The committee's findings, however, will remain secret. "It's covered by Delaware's peer review law," Taylor said.

NAMI-DE Reacts

After Burns' death, the Delaware chapter of National Alliance for the Mentally Ill immediately contacted U.S. Attorney Colm Connolly. "He took it seriously, asked for a summary, and said he'd send it to the experts in Washington," Marocco said. "We were made aware of the allegations, and intend to include them as part of our investigation," Connolly said.

Marocco and McDowell were contacted by a state police detective assigned to investigate the prison death. "State records show Mr. Burns was evaluated by 'the mental health department,'" McDowell said. The name of the counselor who removed Burns from suicide watch was missing. "That's what the DOC calls it — the department — because they're not using doctors," Marocco said. "They might not even be using college graduates."

Marocco issued a written statement, on behalf of her organization, that questions the effectiveness of mental health treatment in Delaware prisons. "The latest tragedy that we are aware of, the tragic death by suicide of Thomas Burns on Tuesday, May 30, 2006 has devastated an entire family," Marocco states. "Prison officials must stand back and re-evaluate why it is that preventable tragedies continue to happen."

Lamb found out her ex-husband was dead about an hour after officers found him. A prison major called her. "It was kind of standard procedure, 'We regret to inform you,'" she said. "Even though he was mentally ill, he really loved the kids and tried to be a good parent. And the kids really loved him."

The above article, entitled "Inmate's Suicide Latest Woe for Prisons," was written by Lee Williams and Esteban Parra, staff writers for The News Journal, and appeared in the June 11, 2006 edition of the newspaper. Copyright 2006, The News Journal. All rights reserved. Used with permission.

New Hampshire

In December 2005, a series of hearings stemming from a class-action lawsuit was held in the courtroom of Merrimack County Superior Court Judge Kathleen A. McGuire. At issue was the adequacy of mental health care for inmates in the New Hampshire State Prison for Men in Concord. Six inmates alleged that the state failed to live up to past agreements or "contracts" for more staffing and mental health programming, including creation of a residential treatment unit for inmates with mental illness. These past contracts were in the form of court settlements agreed to in 1990, 2001, and 2003. According to the attorney for the plaintiffs, the inmates were not asking for monetary damages, only for the state to live up to its contractual obligations.

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

In a meantime, a state legislative study committee was reviewing the prison's Secure Psychiatric Unit and weighing options for renovating, expanding or relocating the unit to a new facility. State Senator Lou D'Allesandro told the *Concord Monitor* that "If we don't do something, the court will decide what we do….Any time you have to live with a court decision, it puts pressure on the state and the legislature. It's better to solve things out of court, if at all possible."

Created last year by the state legislature as a result of the lawsuit, the study committee is not only reviewing the Secure Psychiatric Unit (SPU) but a variety of other state psychiatric facilities. Proposals could include several changes to the state hospital campus in Concord, including adding a new children's treatment facility to the acute psychiatric services building. Also under consideration is a new building for the non-inmate segment of the population now treated at the SPU.

Built in 1985 at a cost of more than $20 million, the SPU was to house both inmates with mental illness and patients who had been found not guilty by reason of insanity or who had been transferred from the state hospital because they posed a danger to others. Mixing the populations, however, has created both management and space problems.

On May 19, 2006, hearings in the case of *Holliday v. Curry*, Equity No. 04-E-0203 (N.H. Sup. Ct.) ended and Judge McGuire ruled that the state had not complied with past agreements to create specific treatment programs for inmates with mental illness. She gave the state 60 days to file a plan that would detail the steps it will take to achieve full compliance with previous agreements. The Court's order included, but was not limited to, the following:

- Defendants shall create a separate housing unit at the New Hampshire State Prison for a Residential Treatment Unit (RTU) for inmates with serious mental illnesses, including personality disorders associated with affective instability, impulse control problems and borderline features, who currently do not require psychiatric hospitalization, but have substantial difficulty functioning adequately within the general prison population due to significant functional impairments. The RTU shall be staffed by a sufficient number of qualified clinical mental health staff, prescriber staff, nursing staff and specially trained correctional officers who are specifically assigned to the RTU. The RTU shall have sufficient and appropriate group therapies and structured activities therapies, which shall include recreational therapy provided by a qualified recreational therapist. Residents of the RTU shall have access to all other prison programs, activities, and services such as medical care, education and vocational training, normally available to inmates in the general prison population.

- Defendants shall staff the Mental Health Unit (MHU) with at least eight (8) full-time equivalent, non-prescriber clinicians.

- Defendants shall provide all of the group therapies that the Chief of Mental Health has already deemed clinically appropriate and necessary for inmates at NHSP, as described in his testimony at trial on December 21, 2005. Defendants shall offer the first such group therapy beginning on the first business day of September 2006. Defendants shall thereafter offer at least one new group therapy on the first business day of each succeeding month until all of the above group therapies are being provided.

- Defendants shall include in their Compliance Plan, draft policies to address the systemic medication delays described in the Court's findings and rulings.

- Clinical appointments shall be scheduled at least every 14 days with each inmate in the Special Housing Unit (SHU) who is prescribed psychotropic medications or is in the Healthy Pathways Program. These clinical visits shall take place outside of the inmate's cell in a clinically appropriate setting in the SHU that ensures both privacy and safety. Such clinical appointments with a MHU clinician shall; be in addition to prescriber medication management visits and "rounds" conducted in the SHU. These clinical appointments shall begin on or before the first business day of September 2006.

- Defendants shall provide on a continuing basis in the Secure Psychiatric Unit (SPU) all of the group therapies that the Director of Medical and Forensic Services has already deemed clinically appropriate for inmates in the SPU….as described in his testimony at trial on December 21, 2005.

- Defendants shall provide such clinical and correctional staff in the SPU as is necessary to provide the above group therapies and structured activity therapies on a regular and on-going basis without undue interruption in programming.

- Defendants shall continue to monitor each inmate in SHU who is prescribed psychotropic medications or is in the Healthy Pathways Program. Such monitoring shall take place at least 30 every minutes, 24 hours a day, seven days a week.

- Defendants shall continue to conduct all mental health precautionary or suicide watches in the Health Services Center or in the SPU.

- Defendants shall begin to prepare a formal treatment plan for every inmate who is prescribed psychotropic medications.

- Defendants shall increase the amount of time over the one to one and half hours per day that such inmates are allowed out of their cells in the E-Ward of the SPU, as well as provide appropriate structured and unstructured activities on E-Ward for such inmates when they are out of their cells.

After reading the court order, DOC Commissioner William Wrenn declined to estimate how much the improved services would cost, but said he would make the Court's deadline and has already made some improvements, such as increasing rounds by correctional staff, adding group therapy programs, and scheduling more frequent mental health appointments. "We have a court decision driving us now," Commissioner Wrenn told the *Concord Monitor* in July, "and there is going to have to be some consensus on the part of the Legislature to making it work. We'll see what they propose and how they interpret the (court) decision."

Alan Linder, an attorney with New Hampshire Legal Assistance, which has been representing the inmates at the prison since 1975, said he was grateful the Judge McGuire agreed with his position at the December hearings that services for inmates with mental illness is a serious and ongoing problem that has not been adequately addressed over the years, despite a number of court orders and settlement agreements the DOC had entered into to provide them. Mr. Linder was optimistic that health care for inmates with mental illness, which can number up to 350 for a population of 1,400, will improve. "It's become apparent to us….that the department recognizes the importance of this issue and it appears to want to address it appropriately," he said. "It's going, however, to need to the assistance of the Legislature."

Coincidentally, the DOC announced in July 2006 that its Division of Community Corrections, Central Office, and Division of Field Services had received accreditation from the American Correctional Association (ACA). The New Hampshire State Prison for Men, which was recently found to have inadequate mental health care, received ACA-accreditation in January 2006 along with three other state prison facilities.

Arkansas

In March 2005, pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. §1997, the U.S. Department of Justice (DOJ) 's Civil Rights Division notified Sebastian County officials that it intended to investigate conditions of confinement at the Sebastian County Adult Detention Center (SCADC) in Fort Smith. Two months later in May 2005, DOJ attorneys and consultants arrived to initiate its on-site investigation. In the end, investigators found that various conditions at the SCADC violated the constitutional rights of inmates, including a failure to provide for inmates' serious medical and mental health needs, right to protection from physical harm, and right to be confined in sanitary and safe environmental conditions.

While the DOJ's investigative findings letter to county officials was rather routine, it was the section on "access to medical care" that caught our attention. The DOJ investigators found that the SCADC required inmates to pay for all medical services and, although the "fee-for-service" system was not unconstitutional per se, the facility's practice of charging inmates fees to access medical care was unconstitutional because it had the effect of deterring access to necessary medical care. According to the DOJ, "SCADC's policy is flawed because it creates a financial disincentive for inmates to seek treatment for chronic and pre-existing conditions, even those which are life-threatening or a threat to the health and safety of others; the policy is not conveyed clearly to inmates; and there is no mechanism to waive the co-payment fees for indigent inmates."

The SCADC policy required that inmates requested medical services by completing a "Medical Division Charge Sheet." The Charge Sheet listed the following co-payments charged for each service:

- **Nurse Call** — $10.00
- **Transportation Fee** — $25.00
- **Over-the Counter Stock Medication** — $3.00
- **Dental Appointment** — "financial arrangements to be set up by family with local dentist, then dentist office to call and set up appointment with jail nurse. Transport fee will be deducted prior to appointment."
- **"Routine" Pregnancy Test** — $20.00 (which must be paid in advance, no negative balance allowed.)
- **Request Release From Suicide Watch** — $10.00

It appeared unclear how SCADC officials arrived at the $10.00 charge for removal from suicide precautions, but the DOJ stated in its findings letter that "in more than 25 years since CRIPA was enacted, we have never encountered a facility which charges for the release from suicide care." We assume that corrective action will be taken in this area.

Utah

Clad in an inmate jumpsuit, Art Henderson sat alone in a cell. For 47 hours, he had nothing but concrete walls to keep him company. Every two days, he was allowed to leave the cell for one hour to shower and make phone calls. That was Henderson's life in maximum security at Salt Lake Metro Jail. Alone in his cell Wednesday night, he hanged himself with a bed sheet.

Henderson, the former Lehi police officer accused of shooting his estranged wife's boyfriend before having a shootout with Lehi police officers, was miserable in jail, said his attorney, Ed Brass. "He expressed his inability to handle the conditions under which he was incarcerated — repeatedly," Brass said.

In jail, Henderson had a lot of time to ruminate on his life — a pending second divorce, his wife's new relationship with another man, the revocation of his certification to be a police officer and, if convicted of charges against him, the possibility of life in prison.

The charges in 4th District Court stemmed from a snowy day in January when he chased Natalie Barnes Henderson and her boyfriend, Craig Trimble, down a Lehi street, firing at them. After ramming the couple's car, Henderson shot Trimble twice, then

turned his gun on Lehi officers arriving at the scene in squad cars. The rampage ended when officers took him down with shots to the knee and foot.

Thoughts of that day's events — and the events that came before and after — may have just been too much for Henderson, Brass said. "My suspicion is that this is the product of some sort of overwhelming depression," Brass said. "He loved his kids so much — I think he must have been in some dark place that didn't allow him to stop and think about the fact that his kids would lose him."

After the shooting, Henderson spent a night at American Fork Hospital, then was taken to the Salt Lake County Metro Jail, where he had been since. He was not taken to the Utah County Jail because he had previously worked there as an officer. Upon arrival, Henderson was evaluated for any perceived suicidal tendencies, said Salt Lake County Sheriff Sgt. Paul Jaroscak. He was put on suicide watch but taken off that list in February when health-care personnel believed he was safe to move out of the jail's health service unit.

Henderson was assigned to maximum security because of the severity of the charges and because inmates often retaliate against incarcerated former police officers. He had been charged with five counts of attempted aggravated murder, one count of aggravated assault, another of domestic violence-related criminal mischief and three counts of unlawful discharge of a firearm.

Officials did not notice signs of distress this week, Jaroscak said. "I'm sure if he had expressed some sort of suicidal tendencies, he would have been immediately taken to the (medical health) unit," he said.

Even Brass, who talked with Henderson a week ago, said he didn't notice anything out of the ordinary. "I know he's been extremely depressed for some significant period of time, (but) his demeanor has always been largely the same," he said.

Officials found Henderson unconscious in his cell around 11:05pm. Wednesday. He pieced ripped bed sheets together to make a rope. Jail officials immediately began CPR and called for backup. Henderson was transported to St. Mark's Hospital and pronounced dead almost 35 minutes later. Officers had last seen him 45 minutes before, during routine checks.

Henderson had pleaded not guilty to the felony charges, and trial was scheduled to start in July. Brass said he was preparing a legal defense based on Henderson's statements indicating he had stopped taking anti-depressants shortly before the January 27 incident.

Brass said that people who stop taking anti-depressants abruptly often suffer severe effects and end up in worse condition than before. Henderson was not himself that day, Brass said. He said Henderson told him he couldn't remember some crucial details of the chase, shooting or shootout. "Our feeling in this case was that — again we were just getting into it — that there were mental and chemical conditions beyond his control that led him to do some things that were out of his control," Brass said. "What we were going to do was to raise a mental health defense based on his state of mind, in the removal of medications."

The Lehi Police Department, where Henderson worked from 2000 to 2004, expressed condolences. "Obviously, we feel for the family during this tragic time," said Lehi Police Sgt. Jeff Swenson. "It's a tough thing to deal with."

A family member said Thursday she wished Henderson could have received the mental health treatment he so desperately needed. She also said the family was tired of seeing the scene replayed and wanted to deal privately with the loss.

Brass said he will file a motion to dismiss the charges. "Art actually was a pretty decent human being," Brass said. "He was very troubled emotionally, obviously. He tended to see things in black-and-white terms and thought that this gentleman that he shot had mistreated his children, and he was angry about that. It's unfortunate that this is the way he will be remembered."

The above article — "Ex-officer Kills Himself: Inmate Was Awaiting Trial in Lehi Shootout" — was written by Sara Israelson, a staff writer for Deseret Morning News, and appeared in the April 21, 2006 edition of the newspaper. Copyright 2006, Deseret Morning News. All rights reserved. Used with permission.

California

In June 2006, the parents of a man who committed suicide in the Contra Costa County Jail filed a federal lawsuit alleging that the county and various other defendants were deliberately indifferent to his medical needs. According to the lawsuit, "the actions and inaction" of jail staff resulted in the death of 28-year-old Robert Clouthier. "This is a death that should not have happened under these circumstances," plaintiff attorney Stan Casper told the *Contra Costa Times*. "This family is seeking to get the county to wake up and see the problems the county has in its jails." Named in the lawsuit were Contra Costa County, the sheriff's department, two deputies and a county mental health clinician. The suit seeks unspecified damages.

As alleged in the lawsuit, Contra Costa Sheriff's Department deputies arrested Mr. Clouthier on July 26, 2005 in connection with a domestic dispute at his parents' home. He was booked into Contra Costa County Jail in Martinez the following day where a mental health clinician placed him on suicide precautions in an observation cell with a safety smock and ankle restraints. At the direction of the same clinician and a psychiatrist, deputies later moved Mr. Clouthier into another observation cell without restraints, but within "line of sight" where deputies could still observe him on precautions.

Later that day, the deputies again moved Mr. Clouthier to another observation cell. He was no longer restrained, but deputies checked on him every 15 minutes and maintained a suicide precautions log. When another mental health clinician arrived during the evening shift, that clinician authorized deputies to discontinue the suicide precautions. According to the clinician, Mr. Clouthier "looked at me directly in the eye, appeared very calm and answered all my

questions. The therapeutic alliance was building between our staff and this man." The clinician, however, recommended that Mr. Clouthier remain housed in the observation cell with regular clothing pending further evaluation.

On August 1, Mr. Clouthier, who had a history of mental illness, was transferred into the mental health housing unit of the facility allegedly by a deputy who was unable to contact a mental health clinician and assumed that inmates who were not on the suicide precautions log did not need to remain housed in an observation cell. Later that evening, Mr. Clouthier was found hanging from a sheet tied to the bunk railing in his cell.

"It all comes down to recognizing the incredible dangers that exist with suicidal inmates and the Sheriff's Department's failure to properly train all of its staff," Mr. Casper told the *Contra Costa Times*. "There clearly was a breakdown between the mental health specialist and the deputy sheriffs that was more than a misunderstanding."

Wisconsin

In July 2006, the state Department of Corrections (DOC) was investigating a death at the Milwaukee Secure Detention Facility in which jail staff waited nine minutes before cutting down and attempting to resuscitate an inmate found hanging in a janitor's closet. Russell Lee Murray, 41-years-old, was found hanging by a bed sheet fastened to a pipe at 7:29pm on June 1, according to a report by the Milwaukee County Medical Examiner's Office. The bed sheet was not cut, however, and cardiopulmonary resuscitation (CPR) efforts were not begun, until 7:38 pm. The report stated that paramedics, who were contacted at 7:32pm, were delayed 15 minutes because they were sent to the wrong location. They later arrived at 7:50pm and continued CPR efforts to Mr. Murray, who was taken to a local hospital before being pronounced dead at 11:50pm.

DOC spokesman John Dipko stated that two corrections officers, one of them a lieutenant, had been placed on paid administrative leave, pending the outcome of an investigation into the death. "We are very concerned about the initial response time," Mr. Dipko told the *Milwaukee Journal Sentinel*. "We as a department take our responsibility very seriously to keep all institutions as safe as possible for inmates as well as guards."

The report from Medical Examiner's Office stated that Mr. Murray had been at the detention facility for approximately three weeks after violating the terms of his probation. He was informed on June 1 that he would be transferred to the Dodge County Correctional Facility to serve a 25-year sentence for sexual assault on a child. That same day, Mr. Murray was told to pack his belongings, which he brought to an officer for inspection. Shortly after 7:00pm, an officer went to give him a conduct report, but the inmate was not in his pod. After the officer began searching for Mr. Murray, another inmate indicated that he might be in the janitor's closet. The officer unlocked the door to the closet and found Mr. Murray hanging from the pipe.

The report also stated that Mr. Murray had a history of anxiety and depression, and had talked of suicide during a recent telephone conversation with his father. ❑

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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Unless otherwise noted, all articles appearing in this newsletter are written by Lindsay M. Hayes, Editor/Project Director.

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 1-14)

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

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