

JAIL SUICIDE/MENTAL HEALTH UPDATE

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In previous issues of the *Jail Suicide/Mental Health Update*, we have regularly discussed the relationship between inmate suicides and liability. And when the discussion turns to case law, we invariably seek the guidance of Fred Cohen, LL.B, LL.M, one of the foremost experts on correctional law and author of *The Mentally Disordered Inmate and the Law*, the definitive text on the topic. He is also Professor Emeritus at the Graduate School of Criminal Justice, State University of New York-Albany, as well as a federal court monitor. The following article is adapted and abbreviated from Chapter 14 of *The Mentally Disordered Inmate and the Law*, 2nd Edition, by Fred Cohen, © 2008 Civil Research Institute, Inc., 4478 US Route 27, Kingston, NJ 08528, and is written here with permission. All rights reserved. The full table of contents for Chapter 14 can be found at <http://www.civicrosearchinstitute.com/mdi.html>. In reviewing the current case law, Professor Cohen argues that, although all inmate suicides are not preventable and plaintiffs face a difficult burden in proving liability, two critical questions should be considered: 1) what policy objectives are reasonable and attainable concerning custodial suicide? and 2) what roles do the courts have in fashioning and enforcing rules designed to reduce — not eliminate — custodial suicide and to provide just compensation where liability is established? Answers to these questions and more follow below.

LIABILITY FOR CUSTODIAL SUICIDE: A LOOK BACK

by
Fred Cohen

Theories of Liability

There are three primary theories of liability presently used in constitutionally grounded, custodial suicide cases, and all must eventually link themselves to the demanding test of deliberate indifference.¹ These theories are:

- ◆ Failure to provide medical or mental health care for a serious medical (or more likely) psychological disorder;
- ◆ Failure to provide a non-life-threatening (or safe) environment; and
- ◆ Failure to train.

The first two theories are far and away the most popular. With the Court's decisions in *Farmer v. Brennan*,² *Wilson v. Seiter*,³ and its earlier decisions in *Estelle v. Gamble*⁴ and *City of Canton v. Harris*,⁵ deliberate indifference is the state of mind requirement for prison (and presumably jail) condition cases, failure to train claims, and also medical/psychiatric claims.⁶ The actual knowledge aspect of deliberate indifference often is the most vigorously contested factual issue. In sorting through what was or was not known, it is also important to link knowledge to a particular risk (or technique).

1) Failure to Provide Care and Failure to Protect

The reported decisions are confused on the precise boundaries of these competing theories and this is especially so for a "failure to protect" claim and a failure to provide medical/psychiatric care claim. When courts analyze a custodial suicide case along mental health care lines, they seem implicitly to accept suicide as caused

by some mental aberration: "Sane persons do not ordinarily kill themselves," stated one early court.⁷

In civil commitment law, modern statutes require a finding of mental illness that also creates a substantial danger of the person causing serious harm to himself or others. Suicide ideation, and certainly a recent attempt to commit suicide, serve as adequate bases for a "dangerous to self" commitment in most jurisdictions.⁸

Professor David Wexler argues that persons who attempt suicide are by no means always mentally incompetent at the time of attempt. Should we save only those who appear to be incompetent and allow the competent the choice of dying at their own hand? Should we honor future valid consents from a rescued but ungrateful incompetent?⁹

The fact that custodial suicide cases present interesting questions concerning committability, and the fact that viewing suicide exclusively as an act of madness or incompetence is dubious, does not affect the custodian's duty to preserve life. As noted earlier, that basic duty flows from custodial obligations and does not depend on the legal basis for custody, the cause or source of the harm or threatened harm, or the acceptance of any particular theory as explaining the harm or threat thereof. However, if one accepts suicide as invariably a sign of serious mental illness, the

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nature of the custodian's duty changes. This may have significant consequences for the particular duty owed the individual and its duration. The duty owed, in turn, may also be seen as varying with the nature of the facility.

Few modern decisions face the dilemma of the relationship of mental illness to custodial suicide more starkly than *Taylor v. Wausau Underwriters Insurance Co.*¹⁰ Taylor was a former corrections officer accused of some heinous crimes against a minor. His mental health screen was uneventful but because of his corrections background and the charges, Fond du Lac, Wisconsin jail officials put Taylor on suicide watch. Federal District Court Judge Griesbach ultimately granted summary judgment for the defendants, but not before trying to parse the duty to provide mental health care and the duty to protect. The judge ultimately, and correctly, concluded:

I am satisfied that the present state of the law is clear—deliberate indifference to a substantial risk of suicide by an inmate, even a completely sane and rational inmate, constitutes a violation of the inmate's constitutional rights. It therefore follows that the fact that Taylor was not mentally ill is irrelevant to his claim against the jail and its officers, except to the extent that the absence of mental illness would have made his suicide less foreseeable. It is enough for plaintiffs to show that prison officials were cognizant of the significant likelihood that Taylor intended to take his own life and that they failed to take reasonable steps to prevent him from succeeding.¹¹

If Taylor had been diagnosed as seriously mentally ill, then of course there would be the possibility of arguing that a failure to provide treatment was causally linked to the suicide. As it was, Taylor hanged himself while under suicide precautions, but during a brief period when he managed to violate the rules and darken his cell. The jail's failure to prevent the cell darkening and the ten-minute delay in rectifying it were held not to constitute deliberate indifference.¹²

2) Treatment vs. Protection

As we have repeatedly seen, a serious mental illness calls for treatment. A suicide threat calls first for prevention and then, perhaps, treatment. However one ultimately defines treatment, it has longer-term objectives and it is more involved than the protection of the individual from himself. The latter duty evokes an insulating function and carries with it no implications for "getting better." Treatment, on the other hand, clearly is an intervention based on a clinical diagnosis and designed to relieve needless pain or suffering and to ultimately ameliorate or cure a particular condition.¹³

Jails and lockups are inherently short-term holding facilities. Longer-term treatment based on a medical model of causation for suicide is far more appropriate for prison, yet it is regularly and uncritically incorporated into the reported decisions involving short-term facilities.

I am not arguing here that mental illness is more or less likely to explain suicides or suicide attempts in prison. I am arguing that longer-term confinement breeds longer term obligations along with

the additional time to arrive at more discriminating causal assessments. Thus, with more time for more discriminating diagnosis and assessment and a longer-term relationship, I would expect mental illness as a cause and as dictating a response to be more at home in prison than jail.¹⁴

a) "Self-Protective" Insulation

The insulation imposed for protective measures may indeed allow, and perhaps invite, stark measures. In *Davis v. Marble*,¹⁵ after a very serious suicide attempt, a plaintiff was confined for ten days in a padded cell with a pit toilet and was given paper clothing. The plaintiff sued for damages, alleging that the harsh condition of his ten-day observational confinement constituted cruel and unusual punishment. The circuit court upheld the lower court's grant of summary judgment for the defendants.

The Seventh Circuit correctly found that whether the plaintiff was a detainee or a convicted person, he was required to show deliberate indifference. With respect to his confinement in the padded cell, Davis alleged that the defendants deprived him of such minimal necessities as adequate clothing, a mattress, and bathroom facilities. However, the defendants took these measures only after a mental health professional directed that Davis be placed on suicide watch, and the precautions were implemented as part of the jail's standard suicide watch procedures. Thus, the court found that the defendants were not deliberately indifferent to the conditions of his confinement, but rather were cognizant of the substantial risk that Davis might again try to kill himself. The jail staff would have been derelict in their duties had they ignored the risk of self-inflicted harm that Davis posed.¹⁶

Drastic measures may be necessary to prevent custodial suicide. In *Myers v. County of Lake*,¹⁷ the Seventh Circuit held that inmates may be deprived not only of belts and ties, but also of pens, sheets, blankets, even clothing, since almost any object may be used to harm oneself. In *Anderson v. County of Kern*,¹⁸ the Ninth Circuit recognized that suicidal inmates might use sinks, standard toilets, and beds to harm themselves and approved use of a padded cell.

The *Davis* court reached the same conclusion as to Davis's claim that the defendants violated his due process rights by keeping him in the padded cell for more than twenty-four hours without periodically reevaluating his need to be there or providing him with meaningful notice and a hearing. Davis was confined in the padded cell as a result of an appropriate exercise of professional judgment by a mental health professional, and that is all that the Due Process Clause required. During his ten-day stay in the padded cell, mental health professionals reevaluated his need to remain there three times and lessened the restrictions as Davis improved. Moreover, while in the padded cell, Davis continued to complain of the severe shoulder pain that prompted him to attempt suicide in the first place.¹⁹

Under ordinary circumstances, or if unduly prolonged, such conditions of confinement may become cruel and unusual. The record in *Davis*, *Myers*, and *Anderson*, however, suggests harsh but reasonable preventive measures. However, where

a potential suicide is left in filth to sleep nude on concrete, such measures should be found to be excessive.

b) Ensuring Physical Safety of Protective Cells

Placing a suicidal inmate in a stark setting for a relatively brief time clearly is legally permissible. The correctional objective is to preserve life, and the conditions of confinement may be sufficiently austere to help achieve that objective. On the other hand, placing a suicidal inmate in a cell that fairly invites an attempt by the suicidally inclined may expose the custodian to liability.

For example, the Nassau County, New York Correctional Facility experienced several inmate hangings from cell coat hooks that supposedly were suicide proof.²⁰ In fact, the hooks allowed material to be weaved through the back of the hook allowing the ligature to be attached to the side supports of the bracket, thereby jamming the hook.

After the death by hanging of one James Gunther and a settlement in the amount of \$875,000, the hooks finally were removed from all cells.²¹ *The Jail Suicide/Mental Health Update*,²² edited and written by suicide expert Lindsay Hayes, points out that too little attention is given to the physical safety of cells, especially to protrusions conducive to suicide by hanging.²³

3) Actual Knowledge

*Viero v. Buffano*²⁴ raises a number of interesting questions on the knowledge aspect of liability. A fourteen-year-old boy who had been in a psychiatric hospital for thirty-three days before being committed to a juvenile facility, who spoke of suicide at his intake screening, and who was prescribed but then not given Ritalin, committed suicide. The case is factually complicated but Judge Shadur did see at least one point clearly:

Defendants miss the point that there are potentially two independent paths to recovery here....For instance, [defendants] argue that because "Ritalin is not to be prescribed for an adolescent diagnosed as suffering from major depression," defendants' failure to ensure that Rosario received Ritalin could not have led to his suicide. That may perhaps be so (although defendants have offered no evidence to support their assertion), but such reasoning perpetuates a mistake made by defendants' throughout their filings. Two possible grounds for liability exist here: defendants' failure to ensure that Rosario's serious medical needs were met, and defendants' failure to protect Rosario from committing suicide. Defendants do not recognize that the former need not be related to the latter for Viero [the mother] to recover under Section 1983 (though the measures of damages would be very difficult). On the other hand Viero could argue that the reason Rosario committed suicide was that he was mentally unstable because he had not been given Ritalin, nor had he been given access to mental health professional since he arrived at St. Charles. But Viero could also independently argue that defendants' failure to ensure that Rosario received Ritalin and had mental health counseling caused harm to him independent of his

suicide. Of course any recovery on the latter theory would be limited to the harm suffered by Rosario without regard to his suicide (e.g., pain and suffering), but she could recover on that theory nonetheless.²⁵

While Judge Shadur did see the separate routes to recovery more clearly than most, his observation on recovery for the alleged medical or mental health failure may be misleading. That is, recovery for suicide based on either of the twin theories should be the same. There is, however, a third point lurking here: the plaintiff-mother might recover for the pain and suffering associated with the medical-mental health failure *independent* of the suicide. This might occur if a fact-finder did not find the risk of suicide serious or sufficiently obvious but did find deliberate indifference as to the medication, failure to counsel, and failure to use existing information.

a) Factors Demonstrating Actual Knowledge

*Jacobs v. West Feliciana Sheriff's Dept.*²⁶ is a good example of a reviewing court following a duty to protect analysis (although without explicitly stating so) and determining that a jury could find that certain defendants acted with deliberate indifference in failing to prevent the suicide of a pretrial detainee. The decision also is of interest for factoring design defect²⁷ into a determination of deliberate indifference. The recitation of factors demonstrating actual knowledge of the risk of suicide also is of interest.

On August 21, 1996, Sheila Jacobs was arrested for attempted second-degree murder. Jacobs had become enraged at her uncle when she learned that he had allegedly sexually molested one of her sons years earlier. The arresting state troopers informed an investigator for the West Feliciana Sheriff's Department that Jacobs told them shortly after her arrest that after shooting her uncle, she had tried to kill herself by placing a loaded gun in her mouth and pulling the trigger, but the gun had jammed. The investigator conveyed this information to Sheriff Daniel and, thus, we do not encounter the information "hand off" problem discussed later in this chapter.²⁸

Sheriff Daniel and Deputy Rabalais both testified that they were indeed told that Jacobs had attempted suicide shortly before her arrest. After processing Jacobs, the officers at the West Feliciana Parish Prison placed her in a "detox" cell, which they use to house inmates who are intoxicated, who need to be isolated for safety reasons, or who are designated for placement on a suicide watch. According to Deputy Rabalais's deposition testimony, when Jacobs was placed in the detox cell, the officers had her on suicide watch and had notified the control center. The various defendants testified that the detox cell could be constantly observed from the jail's control room through a window, but that a substantial portion of the cell, including the bunk area, fell into a "blind spot" not visible from the control room. This cell could be completely observed only if an officer viewed it directly from the hallway.

The cell also had several "tie-off" points (bars and light fixtures from which a makeshift rope could be suspended), despite Sheriff Daniel's acknowledgment that a suicide prevention cell should not have such tie-off points and despite the fact that another inmate had previously committed suicide in the very same cell by

hanging himself with a sheet from one of these tie-off points. To the best of Deputy Rabalais's knowledge and pursuant to Sheriff Daniel's directive, Jacobs was not given sheets on the first night of her detention, August 21.

On August 23, a defense lawyer visited Jacobs at the jail and requested that Sheriff Daniel leave her in the detox cell and perhaps provide her with a blanket and towel. Daniel instructed one of his deputies to give these items to her, but the record reflects only that she received a sheet (which she eventually used to kill herself) and there is no evidence that she received either a towel or a blanket. In his report, the Sheriff stated that he had been thinking about moving Jacobs to another cell with other female detainees, but decided to leave her in the detox cell after she asked him not to move her because she was afraid the other women would hurt her. He also noted that when Jacobs had asked for her hepatitis medication, she had given no further indication that she was planning to attempt suicide or to harm herself.

Deputies Reech and Rabalais were on duty at the jail facility from 11:30 P.M. the night of August 23 until 7:30 A.M. the next morning, August 24. The record reveals that the defendants still regarded Jacobs as a suicide risk during that time. Indeed, Sheriff Daniel testified that Jacobs was on a "precautionary" though not a "straight" suicide watch. The court's review of the record revealed few discernible differences between these two types of suicide watches.

When an inmate is on "strict" suicide watch, the jail's informal policy was to have the inmate visually monitored every fifteen minutes. Deputy Reech testified that he and Deputy Rabalais made periodic checks on Jacobs; however, it was unclear exactly how often the deputies checked on her while she was under the "precautionary" suicide watch. What was clear was that as many as forty-five minutes elapsed from the time a deputy last checked on Jacobs to the time she was discovered hanging from the light fixture in the detox cell.

Specifically, the record revealed that after having observed Jacobs in the detox cell at 12:22 A.M. and at 1:00 A.M., Deputy Reech checked on her at 1:22 A.M. and observed her lying awake in her bunk. At 2:00 A.M., Deputy Rabalais went to investigate some loud music down the hall and on his way back to the control station, he observed Jacobs lying awake in her bunk. Deputy Rabalais testified that both he and Deputy Reech checked on Jacobs sometime between 2:00 A.M. and 2:44 A.M., and that Jacobs was still awake in her bunk. After this last check, Deputy Reech returned to the jail lobby to read his newspaper.

At approximately 2:44 A.M., Deputy Rabalais looked into the detox cell from the control room and saw what appeared to be part of an arm hanging from the ceiling. Concerned, he went to find Deputy Reech (who was still reading the newspaper) to help him get into the detox cell. When the deputies arrived at the cell, they found Jacobs hanging from a sheet that had been tied around the caging surrounding a ceiling light fixture. Deputy Rabalais found a knife and enlisted the assistance of another inmate in cutting the sheet and lowering Jacobs onto the floor. By all indications, Jacobs had torn a small string from the bunk mattress and wrapped that string around the sheet to form a

makeshift rope. The paramedics who arrived only moments later were unable to resuscitate her.

Jacobs's suicide was the third suicide at the jail during Sheriff Daniel's tenure there. As we noted, an earlier suicide had occurred in the same cell where Jacobs killed herself, while the third suicide had occurred in a cell down the hallway from the detox cell.

Jacobs's survivors sued the sheriff and his deputies in federal court for damages alleging deliberate indifference to the decedent's obvious need for self-protection and also for failure to accommodate the medical and mental health needs of detainees such as Jacobs. The defendants moved for, and were denied, summary judgment on the grounds of qualified immunity. The Fifth Circuit's decision basically upheld the lower court's denial of summary judgment and allowed the case to proceed.

The magistrate judge below found that Sheriff Daniels and the two deputies all had subjective knowledge that Jacobs posed a serious risk of suicide throughout her confinement. The judge found that despite this knowledge, the defendants:

- (1) [P]laced Jacobs in a detox cell that purportedly permitted constant observation from the control room but which in fact had a substantial "blind spot;"
- (2) allowed her to have loose bedding (to be used in the "blind spot," i.e., the bunk) despite defendants' admission that this was not advisable for a potentially suicidal person;
- (3) allowed the loose bedding in a cell that had multiple "tie-off" points despite Sheriff Daniel's acknowledgment that a suicide prevention cell should not have tie-off points and despite one of the still-uncorrected tie-off points having been used in a prior suicide;
- (4) left Jacobs essentially unobserved for an as yet undetermined period of time, up to three quarters of an hour, in violation of Sheriff Daniel's unwritten policy of quarter-hour checks. Deputy Reech, who apparently had the keys to the cell block, was reading a newspaper in the lobby.²⁹

The magistrate judge found that all of these factors precluded a finding that the defendants' conduct was objectively reasonable in light of the deliberate indifference standard. The magistrate judge evaluated the conduct of all three defendants collectively, while the Fifth Circuit engaged in an individual analysis and concluded that Deputy Rabalais, with only six months' experience and with no direct decision-making as to cell placement or the decision to place sheets in Jacobs' cell, acted reasonably.

For the sheriff and senior deputy, the court conceded that after the establishment of a known risk of suicide, the law is far from clear on exactly what duty, except that of generalized "prevention," is required.

Sheriff Daniel was aware that Jacobs had tried to kill herself once before and that she posed a serious risk of trying to do so again; he considered her to be a suicide risk throughout the time she was in the jail. Under Sheriff Daniel's supervision, Jacobs was placed in the detox cell, which had a significant blind spot and tie-off points, despite the fact that during Daniel's tenure another detainee

had committed suicide in the same cell by hanging himself from one of the tie-off points. Specifically, that detainee tied a blanket around one of the bars in the window of the detox cell and hung himself by fashioning the secured blanket around his neck and sitting down. Deputy Reech, and not Sheriff Daniel, initially ordered Jacobs to be placed in the detox cell. Nevertheless, Sheriff Daniel effectively ratified that decision by keeping Jacobs in the cell while he considered her to be a significant suicide risk. Moreover, Sheriff Daniel ordered his deputies to give Jacobs a blanket and towel, despite the fact that he still knew that she was a suicide risk. He did not offer any reason for doing so other than Jacobs's appointed counsel's suggestion that she be given these items. In fact, he acknowledged that a suicidal person should not have loose bedding of any kind in his or her cell. (Recall that a sheet was used in this hanging and apparently an unknown employee misunderstood the blanket and towel order and instead provided the sheets.)

Sheriff Daniel also acknowledged that it was not advisable to place a suicidal detainee in a cell with tie-off points, even though the detox cell did have tie-off points. With full awareness that a prior suicide occurred in the detox cell by way of an inmate securing a blanket to a tie-off point therein, Sheriff Daniel did nothing to eliminate or conceal the tie-off points in the detox cell, which his unwritten policy mandated as the appropriate cell for housing suicidal detainees.

Sheriff Daniel did not completely ignore Jacobs's suicidal condition and instituted some preventative measures, including not allowing her to have loose bedding during the first one and one-half days of her detention and instituting more frequent checks on her. However, those measures were not enough to mitigate his errors, and overall his conduct was objectively unreasonable in light of his duty not to be deliberately indifferent.

The court concluded that there was sufficient evidence in this record for a jury to find that Sheriff Daniel acted with deliberate indifference to Jacobs's known suicidal tendencies. A similar, although not factually identical, analysis was employed for senior deputy Reech.

One message here is loud and clear: once there is an obvious (courts say "serious" but they mean obvious or likely) suicide threat in a jail setting, there must be constant or at least close observation, and any jailer who uses a cell (or room) for a potential suicide with readily accessible tie-off points is flirting with deliberate indifference should a suicide occur. All such cells should be closely inspected. Where there are blind spots, add a corner or plastic mirror, or enlarge the cell window as needed; look for tie-off areas and correct them; look for, and eliminate, protruding sharp points; have a policy; and train your staff.

b) Imputing Knowledge to Staff

*Taylor v. Wausau Underwriters Insurance Co.*³⁰ raises an issue that I cannot recall previously encountering: the extent to which knowledge of suicide risk may be inputted to staff from knowledge that a prisoner is on suicide watch in a "safe cell."³¹ The judge initially confused degrees of risk with a discussion centered on

real versus perceived risks, and then further confused the matter by correctly finding no deliberate indifference but for the wrong reasons.

Taylor, as a former corrections officer and accused of a heinous crime involving a young female, was found to not be mentally ill but deemed a suicide risk because of his former employment and the crime charge. Fond du Lac, Wisconsin Jail officials prudently placed Taylor in an observation cell under suicide precautions. Staff discovered a razor secreted in the cell and an elastic band torn from his underwear, and also noted lacerations on his arm. In violation of jail policy, Taylor managed to extinguish the lights in his cell and hang himself in some unspecified fashion. There was only about a ten-minute darkness episode.

The court was clearly correct in finding no custom or policy by the County violative of any constitutional right. As for the officer on duty that fateful night, he, of course, should be charged with knowledge of actual risk (although the degree may be debated), but I discern no evidence of deliberate indifference. Indeed, the darkness is more a condition than a cause of the suicide. More importantly, a suicide watch creates knowledge of the risk of suicide, the *Taylor* judge notwithstanding. Indeed, it defies elementary logic to not always impute knowledge of suicide risk from knowledge of a suicide watch.

4) Limitations of Deliberate Indifference Standard

In *Zwalesky v. Manistee Co.*,³² the decedent was arrested on a complaint of spousal abuse. He was drunk, swore and yelled in the police car, banged his head on the car's screen, and threatened to kill his relatives and himself. The decedent was placed in a so-called detoxification cell and about ninety minutes later was discovered to be dead, hanging by his shirt from a conduit pipe in the cell.

The trial judge granted summary judgment for all the jail-connected employees, finding they were immune from suit because there was no showing of any clearly established right possessed by the decedent that reasonable public officials should have known.³³ *Zwalesky* involves the two theories of liability discussed above: denial of medical care and denial of the right to be free from unsafe confinement. The court stated that the right actually asserted was a detainee's right to be screened for suicidal tendencies and then to have appropriate preventive measures taken. The court said that the general right to medical care was not sufficient to establish a clear constitutional right to be screened for psychological problems.³⁴

Of course, the court ignored the fact that this individual, who may be in the interim status between arrestee and detainee, actually threatened to do violence to others and himself. Thus, this case did not raise the general issue of psychological/suicide screening and did not involve fine distinctions of underlying cause. Indeed, this was not a case in which the court discussed the authenticity of the suicide threat. The case fits so many of the standard factors on the jail suicide profile developed by the National Center on Institutions and Alternatives (NCIA), as well as the most demanding informational requirements for a suicide alert, that it dramatically illustrates the strictures of deliberate indifference and judicial confusion on liability theories.³⁵

The court went on to hold that the exercise of professional judgment did not require prison (or jail) officials to make accommodations for potential suicide attempts and that the failure to include suicide prevention procedures for processing incoming detainees did not violate any clearly established constitutional rights.³⁶

This is about as tough as it gets for plaintiffs and about as forgiving as it gets for custodians. *Zwalesky* should not have been analyzed as a general screening case and it need not have involved any immediate claims to remedial medical or psychiatric care. The most reasonable claim would have been to the standard and inexpensive measures associated with a suicide watch³⁷ and removal of any implements of potential self-destruction.

Hypothetically, if this suicide victim had survived and then been convicted and sentenced to prison, I would then argue that at a minimum:

- ◆ The suicide-attempt information should accompany him to prison;
- ◆ Prison authorities have a heightened diagnostic-evaluative obligation at reception; and
- ◆ If suicide ideation continued, it would be reasonable to then diagnose a serious illness calling for appropriate mental health care and a protective process and environment.

In other words, the authorities would be put on clear notice of a high suicide risk. While general suicide screening in jails arguably may not be mandated, there would still exist an obligation here of “information transfer” and a consequent “suicide alert.”

In *Belcher v. Oliver*,³⁸ the Fourth Circuit adopted the position that “The general right of pretrial detainees to receive basic medical care does not place upon jail officials the responsibility to screen every detainee for suicidal tendencies.”³⁹ In so doing, the court aligned itself with earlier decisions by the Third, Fifth, Sixth, Ninth and Eleventh Circuits. At first blush, such a position may seem to be unduly harsh and not sufficiently protective of persons in confinement. However, millions of persons are processed annually through jails and lockups and many are held only for a brief time while awaiting arraignment, release on bond, sobering up, a relative, and so on. Courts are reluctant to allow highly intrusive searches of arrestees without reference to the reason for arrest, the special characteristics of the arrestee, and the projected duration of confinement.⁴⁰

However, once again, the courts generally seem to misapprehend the issues. Even if we stipulate to the legal correctness of “no general duty to screen,” that does not mean there is no duty to screen or assess persons presenting certain characteristics or who are members of a particular at-risk group more vulnerable to suicide.⁴¹

Reasonable people may well disagree about what characteristics or signs in what combination should create the duty to develop further information, but it does not seem reasonable to adopt the *Belcher* “no duty at all” position and then shut down the debate.

The *Zwalesky* hypothetical discussed above surely is an example of where a duty should exist.

In the context of a decision to deprive a person of his liberty, serious questions are—and should be—raised about the ability of experts to predict dangerousness to self or others.⁴² In our context, liberty invariably has been taken and the question is the preservation of life and health.⁴³ With jail and lockup suicides tending to occur in isolation, early in the confinement, by relatively young, white males who are “high,” who have not been screened, and who then “hang up” in the early morning hours, how much effort and training would it take to use these factors as triggers for additional screening and/or special precautions?⁴⁴ Very little, it would seem.

Any errors in screening and short-term precautions would likely impose little cost on the facility and hardly any dignitarian costs on the person in custody. Yet, the courts are moving in a direction that positively discourages the development of either information or expertise. Plainly, *Farmer v. Brennan*⁴⁵ has not reversed this trend.

The Information Problem in the Deliberate Indifference Standard

1) Inference of Actual Knowledge

In *Freedman v. City of Allentown, Pennsylvania*,⁴⁶ we encounter a variation on the *Belcher* formula. *Belcher* (and the several cases in line with it) deals with the custodial duty to screen and develop information, whereas *Freedman* deals with the obligation to interpret certain signs as indicative of a suicide risk. In *Freedman*, an officer observed scars on the confined individual’s wrists and inside his elbows and neck—signs generally indicative of prior suicide attempts—but failed to interpret them as indicia of suicidal tendencies. The scars were prominent. The court stated, “[W]e will assume that a reasonably competent prison official should have known and identified these marks as ‘suicide hesitation cuts’ . . . Even if so, the failure to recognize them as such, without more, amounts only to negligence and therefore fails to support a claim.”⁴⁷

Judge Brotman, dissenting in part, pointed out that a detective questioned Freedman for over two and one-half hours and asked about scars that he then displayed. Characterizing the majority’s position as an unilluminating conclusion, the dissent went on to state:

I remain unconvinced that Detective Balliet’s inability to recognize the tell-tale signs of a high risk individual can never amount to “recklessness.” I fail to see how the majority can be so resolute in its position without knowing the extent of the police officer’s background and training in detecting suicide risks and in suicide prevention, in addition to his prior experience with prisoners who have taken their own lives or attempted unsuccessfully to do so. None of the information concerning the officer’s knowledge, experience and professional competence would likely be known even to the most diligent civil rights plaintiff at the pleadings stage, and, therefore, he should be entitled to adduce such pertinent facts through discovery.

For example, discovery might reveal that Detective Balliet was a veteran police officer who had received extensive training in suicide prevention and had become well-versed in detecting the indicia of suicidal propensities. It is not unlikely that such a veteran officer would have seen bodily markings similar to the ones on the decedent's body in the course of his duties, nor is it improbable that he would have come into contact with a prisoner bearing such markings who had committed or attempted to commit suicide. Surely a reasonable jury could conclude that a police officer possessing such knowledge, training, and experience acted "in disregard of a known or obvious risk that was so great as to make it highly probable that harm would follow." *See* W. Page Keeton, *Prosser and Keeton on Torts* Sec. 34, at 3213 (5th ed. 1984).⁴⁸

Nonetheless, the majority view prevailed and the plaintiff's case was dismissed. Here, then, we have obvious and objective signs that might easily have alerted the custodians to the need for effective preventive measures. The majority, however, refused to impose a constitutional duty of knowledge in the interpretive sense on police officers and, presumably, jailers. This, it seems, is the sort of permissible inference from circumstantial evidence that Justice Souter had in mind in *Farmer v. Brennan*.⁴⁹ That is, the officer's prior experience and training, once established, plus what he saw (the scars), could easily lead to an inference of actual knowledge of risk.

In *Glenn v. Borough of Morrisville*,⁵⁰ a robbery suspect committed suicide by hanging with his own belt while confined in a police holding cell shortly after his arrest. Once in his cell, the suspect was unhandcuffed and his belt and shoes were removed by Officer Apice, who placed them on the floor about four feet from the cell. Without being told precisely how, the court learned that the suspect shortly thereafter retrieved his belt and used it in the suicide. The federal district court granted much of the defendant's motion for summary judgment on claims related to the use of force and failure to train but refused such judgment to Apice, who dealt directly with the decedent as to the handcuffs and placement of the clothing.

The plaintiff produced evidence that Glenn was particularly vulnerable to suicide (documenting depression and a previous suicide attempt). The record also contained evidence that Glenn's prior suicide attempt left visible scars, or "hesitation marks," on his wrists and that in removing handcuffs, an officer might well notice "hesitation marks" on a detainee's wrists.

There also was evidence that it was not Apice's custom to remove a detainee's shoes and belt, which was supplemented by further evidence that while there was no departmental policy regarding removal of a detainee's clothing, officers would remove shoes and a belt from a detainee if they recognized that the detainee presented a suicide risk. Viewed in the light most favorable to plaintiff, the court determined that the evidence permits the reasonable inference that Apice exercised his discretion to remove the articles because he knew that Glenn was particularly vulnerable to suicide. In contrast to *Freedman* on the actual knowledge element, this court allowed for visible scars and, more important, the officer's suicide prevention conduct.

The decision by Apice to place the clothing so close to the cell may have evidenced a type of recklessness depending on the

officer's knowledge and internal decision-making process. That fellow officers, and Apice himself, used other areas for the placement of the clothing at least allows for an inference that the clothing was placed where it was out of a lack of concern for the decedent.

Since this is a ruling on summary judgment, I must point out that some of the possible inferences as to knowledge or reckless placement may, but not must, be drawn. As a gratuitous aside, this is the type of case that should have settled.

2) Failure to Train or to Create Policy

a) Need to Avoid Rewarding Ignorance

Does the *Freedman* majority approach place a premium on ignorance, or does it encourage possible life-saving information? Obviously, the majority opinion favors ignorance and, not so obviously, so does the dissent. Judge Brotman's speculation about discovery possibly producing information on training and expertise and thus creating the potential for deliberate indifference may also be taken to mean that if no such training or indicia of competence was forthcoming, then the officer's ignorance bars recovery. That is, sound legal policy here may be to insist on this type of training in the face of the regularity and seriousness of custodial suicide.

Have we reached a point in time when jail and lockup suicides are so prevalent, and the steps necessary to prevent or drastically reduce these tragedies so well known and affordable, that a constitutional obligation of at least minimal training is now in order? I believe so, but not only is support for this lacking in the leading decisions, the courts actually induce ignorance by rewarding it.

In *City of Canton v. Harris*,⁵¹ the Supreme Court outlined the conditions under which a municipality might be liable for a custom or policy of failure to train. The municipality itself, not its agents, must be the direct cause of the violation, and the failure to train must amount to deliberate indifference to the rights of persons with whom the agency comes into contact. There must be a deliberate choice to follow a course of action from among various alternatives and there must be a direct link between a specific deficiency in training and the ultimate injury. Failure to train claims will not succeed simply by showing that harm might have been avoided with more or better training.

Putting a lethal weapon into the hands of a police officer with no training in its handling and no clear policy on deadly force is probably the clearest example of a potentially successful failure to train lawsuit. I would suggest that with so many custodial suicides, with so much predictive information readily available and usable by anyone sufficiently competent to work in corrections or law enforcement, and with prevention measures available at no significant cost, it is time for *Canton* to be applied to this area. At a minimum, where a facility has experienced a recent custodial suicide, this should be taken as prima facie evidence of a need for some training.⁵²

b) Cases Where Failure to Train Led to Liability

Liability on the basis of failure to train has had something of a resurgence, at least in the area of custodial suicide. Two cases are

illustrative. In *Smith v. Wynn & Harris Co.*,⁵³ a teenager hanged himself while in the custody of Delta 3 Boot Camp, a juvenile detention center operated by Harris Co., Texas. The young man had been diagnosed as suffering from severe depression and attention deficit disorder and was treated with various medications. During his four months at Delta 3, the young man threatened suicide and harmed himself on several occasions, but staff took no precautions. The juvenile began refusing to come out of his cell and hiding under his bed. Staff then placed him in solitary confinement. On September 2, 1997, he was found hanging from his bed sheet, which was attached to a loose sprinkler head in his cell. Initial reports showed visual checks on the cell every fifteen minutes. It was subsequently discovered that those reports had been altered and that the boy had been dead for at least one hour before discovery. Two officers admitted that it was routine practice at Delta 3 to fill out inspection reports in advance to speed up “onerous” paperwork.

The federal district court denied the defendants’ motion to dismiss and clearly signaled that there was a basis for liability on a failure to train theory.⁵⁴ A municipality may be liable for the adoption of a policy or custom that leads to a constitutional deprivation. While there is no constitutional mandate to train officers to medically screen each detainee, a demonstration of a failure to more generally train may be enough to establish the required custom or policy. The failure to train must amount to deliberate indifference, and that failure must be the “moving force” behind the injury. The defendant’s admission that it was routine practice to prerecord inspection records and the subsequent lies about the visual checks supported the failure to train theory.⁵⁵ The motion to dismiss was denied.

Curiously, this brief opinion says nothing about the rather obvious risk of suicide or self-harm this troubled young man presented. On the facts the risk was high, and given the devastating admissions as to falsification of records and the failure to follow protocol, liability seems fairly clear.

The court did not actually make a strong case that liability should be based on the failure to train. One might have the best training program devised and still have an unprofessional or corrupt employee. It is not training alone that can cure such a problem, but some type of quality assurance program that would detect the record falsification and support better preventive care for suicidal detainees.

In *Mary Ellen Owens v. City of Philadelphia*,⁵⁶ the federal district court denied the defendants’ motion for summary judgment, and the city thereafter settled the case for \$440,000. The “failure to train” aspect of this case will not immediately emerge as the case narrative that follows unfolds:

On July 17, 1992, Gaudreau, the decedent, was incarcerated at the Philadelphia Detention Center (“the Detention Center”) after he allegedly violated a state-court protective order prohibiting him from harassing his parents. On July 22, 1992 Gaudreau was transferred, pursuant to an involuntary mental health petition, to the Hahnemann Correctional Mental Health Services Unit (“Hahnemann Unit”). The Hahnemann Unit is a mental health services

facility opened by Hahnemann University and located in the Health Services Wing of the Detention Center. The basis for the petition was a report that Gaudreau had set a fire in his cell and was kicking the cell’s window. Upon admission to the Hahnemann Unit, Gaudreau was diagnosed as “bipolar manic with psychosis.” In the examination report, he was found to be “hostile, verbally abusive toward the doctor and correctional officers” and to have “anger outbursts, antisocial attitudes and assaultive ideas.” There was a check in the box denoting: “The patient is severely mentally disabled and in need of treatment.” Gaudreau’s treatment consisted of admission to the Hahnemann Unit as an inpatient, with assault and fire precautions, and a course of antidepressant medication.

The next day, July 23, 1992, a judge ordered Gaudreau to undergo a mental health evaluation to determine whether he should be committed. He was then remanded to the Philadelphia Prison System to be assigned for the evaluation. Between July 23 and July 25, 1992, Gaudreau was again incarcerated at the Philadelphia Detention Center. On July 25, he was readmitted to the Hahnemann Unit. The admission summary indicated a host of psychiatric symptoms, including: excessive and pressured speech, angry outbursts; hostility and agitation; inappropriate, demanding, and threatening.

Gaudreau was hospitalized in the Hahnemann Unit from July 25 to August 4, 1992. He was treated by Dr. Sharon Wainwright, who noted that Gaudreau had a prior history of psychiatric hospitalization. During this period, Gaudreau was placed in restraints twice and there was initially some difficulty in getting him to take his medication. On August 4, 1992, Gaudreau was discharged as an inpatient and returned to the cell block, where he was treated as a Hahnemann outpatient. Gaudreau was assigned to a unit housing other Hahnemann Unit outpatients. On August 11, he was interviewed by a Hahnemann social worker who noted that Gaudreau “still sometimes has passing thoughts of hurting self or doing something to himself.” Gaudreau remained at the Detention Center until his suicide on August 14, 1992.

On that day, defendants Sean Murphy and Preston McDaniels were the correctional officers assigned to the unit from 7:00 A.M. to 3:00 P.M. At approximately 1:30 P.M., Gaudreau approached Murphy. At his deposition, Murphy testified that Gaudreau “stated that he felt schizy and he was going to hurt himself.” Murphy then telephoned the Hahnemann Unit and spoke with Dr. Wainwright, the psychiatrist who had most recently treated and discharged Gaudreau. Murphy informed Wainwright of Gaudreau’s statements. Murphy testified that Wainwright responded by saying that she was extremely busy at that time but would issue a pass for Gaudreau to be released to the Hahnemann Unit at 3:00 P.M. Murphy also stated that Wainwright opined that “this sounds like someone who just wants to get off the block.” Wainwright also testified that she wrote a pass for

Gaudreau at 2:00 P.M. authorizing Gaudreau to come to the Hahnemann Unit between 3:00 and 3:15 P.M.

After this phone conversation, Officer Murphy spoke to Gaudreau, informing the detainee about the pass that would be issued.

Gaudreau then walked away in the direction of the prison's gym. At approximately 2:20 P.M., Gaudreau asked Officer McDaniels if there was a pass for him to see the doctor. At approximately 2:40 P.M., Wainwright noticed that the pass had not been delivered. At approximately 2:45 P.M., Gaudreau returned from the gym and Murphy locked Gaudreau in his cell

alone. Murphy made no entry regarding any of these events in the officers' log. When he was relieved at 3:00 P.M. by officers Eric Lewis and Wayne Robinson, Murphy did not inform the incoming officers of Gaudreau's statement or the fact that a pass was going to be issued. Nothing in the record suggests that the pass was ever delivered.

Lewis and Robinson were assigned to the unit from 3:00 P.M. to 11:00 P.M. Lewis began an inspection tour at the commencement of the shift. Lewis testified that when he looked into Gaudreau's cell, he saw the detainee lying on his cot. Robinson testified that, while at the control booth at approximately 3:35 P.M., he received a phone call from Wainwright, who stated that she had a pass for Gaudreau and asked why Gaudreau had not shown up for his appointment. Robinson asked an "inmate worker" to see if Gaudreau was in his cell. The worker shouted to Robinson that Gaudreau had hanged himself. Robinson testified that he ran toward the cell, but could not reach it or see inside because 15 or 16 inmates were gathered there. He then returned to the control booth and informed Wainwright that Gaudreau appeared to be hanging in his cell. Lewis testified that he then went to the cell for the first time and observed Gaudreau hanging (but he never actually entered the cell).

After returning to the control booth, Robinson called Sergeant Gail Morris at Center Control. Morris informed Lieutenant William Russell who, with Correctional Officer Nicole Brown, went to Gaudreau's cell. Neither brought anything with which to cut Gaudreau down. When they arrived at approximately 3:40 P.M., Robinson was in the control booth and Lewis was at the threshold of the cell. Russell and Brown observed Gaudreau hanging by a bed sheet which was tied to a clothes hook, which was approximately five feet from the floor. According to an internal investigative report and the photographs of the

scene, Gaudreau was hanging in a sitting position. Lt. Russell directed Brown to find an instrument with which to cut the body down. Brown was unable to find any such instrument. It is uncontested that none of the officers on the scene attempted to untie or remove the sheet.⁵⁷

The facts shout 'high degree of risk,' and along with the concern about risk they show a generalized confusion and ineptitude. Whether the risk awareness and official conduct amounted to deliberate indifference is a key legal issue, and whether 'failure to train' is a sustainable legal theory is even more interesting.

To be kind, one would have to say this was not a model approach to either suicide prevention or post-suicide attempt behavior. The facts fairly shout "high degree of risk," and along with the concern about risk they show a generalized confusion and ineptitude. Whether the risk awareness and official conduct amounted to deliberate indifference is a key legal issue, and whether "failure to train" is a sustainable legal theory is even more interesting.

It is not clear that Gaudreau was a pretrial detainee, since the protective order he was initially accused of violating appears to be a civil order. No matter, at least in this case. Judge Lewis Pollack, a distinguished former law professor, elected to confer pretrial detainee status. The judge worried, needlessly in my view, about whether deliberate indifference here required actual knowledge of the risk of suicide or whether the less demanding objective standard of "should have known" applied. Since *Farmer v. Brennan*,⁵⁸ there can be no doubt that actual knowledge of risk is required. However, if there is a basis for actual knowledge on the facts—as the judge here ultimately determined—then the debate on "should have known" is moot.

There appear to be three somewhat independent bases for the plaintiff's claims:

- ◆ A failure to take reasonable precautions to avoid the suicide in the face of actual knowledge of the risk.
- ◆ A failure to take reasonable ameliorative measures after the hanging was discovered. This is cast as a failure to provide needed medical care, which may have been lifesaving, just after the deceased was discovered hanging.
- ◆ A failure by the city to train officers, amounting to an actionable city policy or custom. Failure to train claims are nearly always defeated, and the plaintiff's victory here (as developed below) is highly unusual.⁵⁹

Keeping in mind that the plaintiff's task here was limited to defeating the motion for summary judgment, the plaintiff actually prevailed on the facts as recited and, for some named defendants, on each of these theories.

1. *No reasonable precautions.* Correctional officer Sean Murphy was the equivalent of a witness who visits plaintiffs' counsel only in their dreams. His deposition laid the groundwork for establishing the actual knowledge requirement of deliberate indifference. He stated that Gaudreau told him he was going to hurt himself. Murphy attempted to get help, without recording his activity; the help did not come in time; he failed to notify the second shift officers of the

problem; and he had to know there was generalized risk because of the characteristics of the inmate population on the unit.

Judge Pollack found that a jury might view all of this as deliberate indifference. Curiously, the judge did not explore, as many other federal judges do, the issue of whether the threat of self-harm had facial validity. Was it credible?⁶⁰ In light of the decedent's active and known psychiatric history, perhaps the judge may have deemed the validity of the threat and its ominous meaning so obvious that analysis would be redundant.

There also is an interesting "information hand-off" issue here. If the second shift officers had been legally pursued on this legal theory—that is, failure to prevent the suicide—then they likely would prevail on a claim of "no actual knowledge" of the risk. Here, Murphy effectively implicated himself in his failure to follow through on a suicide alert with a known expression of suicide (or self-harm) intent made only minutes before a shift change.

2. *No reasonable ameliorative measures.* The response of two correctional officers to an alarm about a possible suicide was characterized as confused and disorganized. They did not elevate the victim, untie or loosen the noose, give CPR, monitor and maintain an open airway, or have or obtain proper equipment. The court stated, "On this record, a jury could reasonably conclude that there was inaction in the face of a serious medical need of which the officers were aware and that such inaction violated Gaudreau's rights under the Due Process Clause."⁶¹

As a matter of law, it does not matter how an inmate comes to be in a life-threatening situation. Corrections officers are bound to preserve life whether an inmate is struck by lightning or impaled by his own hand. The record as developed did not permit an answer as to whether the victim was alive and resuscitable when found, but there was enough for the judge to deny summary judgment.

3. *No training policy for officers.* In *City of Canton v. Harris*,⁶² the Supreme Court held that a city may be liable for a failure to train officers when the failure equals a policy or custom and amounts to deliberate indifference. The Court held that the need for such training may be so obvious and the inadequacy so likely to result in a violation of constitutional rights, that the city policy makers may be said to be deliberately indifferent. The plaintiffs must identify the deficiency and also show a causal connection to the claimed indifference by the officers. This, to say the least, is often impossible to prove and especially when an isolated failure to train will not translate into a policy or custom.

In *Owens*, the city pointed to a short 1998 memo of one and one-half pages, actually a directive, as evidence of their commitment to training on suicide issues. If this document represented the City's dedication to training, it was so brief and general as to fail as evidence to support summary judgment. Even if actually used, there is evidence the memo was ineffective. None of the deposed officers could recall this training, the memo, or any retraining on prevention, first aid, or CPR. Beyond having conducted a class on point and the existence of a couple of inconclusive memos, the City was found to have offered no evidence to refute the plaintiff's claim of inadequate training.⁶³

Kenneth M. Dubrow, Esq. of Philadelphia was the successful lawyer for the estate. In a telephone interview, he informed me that to his knowledge the \$440,000 settlement he obtained was the highest amount paid by Philadelphia in a case of this sort. Asked what he viewed as the strength of his case, he unhesitatingly replied: the absence of policy and procedure and poorly trained correctional officers who, among other things, at their depositions appeared to have absolutely no knowledge even of the indicia of suicide. Mr. Dubrow also suggested that with the adoption in 1992 of comprehensive policies on point, Philadelphia may not now be vulnerable on that basis.

Officer Murphy, the plaintiff's dream witness, testified under oath that the decedent said he was going to hurt himself. This satisfied the judge as to the actual knowledge requirement of deliberate indifference. Instead of a cellie or fellow detainee swearing to the threat, there was an actual defendant providing the evidence. When asked what the plaintiff's strongest theory of liability was, Mr. Dubrow surprised me by answering that it was the failure to train. That failure when linked with no relevant knowledge about custodial suicide and the officer's admission surely prompted the City to open its wallet and settle.

Lessons to be learned? Well, first, if someone tells you suicide training is a luxury, worth a two-hour slot at preservice and a nod during an inservice, do not pay attention. Jails and prisons need clear policies and procedures, training and retraining, and a decent quality assurance program.

Liability avoidance, of course, should not be the motive force. Saving the lives of people who are desperate, who need help, is a much loftier motive. Saving staff from the inevitable trauma they experience, avoiding the inmate unrest that usually follows a suicide, are motives not to be denigrated either.⁶⁴

c) The Information-Interpretation Problem

Returning to the *Freedman* scenario, the issue there will be characterized as information interpretation. That is, the officer had relevant information—the multiple, severe scars—and the issue was his alleged failure to understand their significance. We might again note that even if this information had been properly translated into an awareness of a high probability of suicide, the plaintiffs would still have been required to prove that the response, or lack thereof, was constitutionally deficient—that is, deliberately indifferent.

The *Freedman* information-characterization problem has arisen in other cases. In *Bell v. Stigers*,⁶⁵ an eighteen-year-old DWI arrestee told the booking officer that he thought he would shoot himself. The booking officer apparently bantered with the youth and replied that it was too bad, but he did not have a gun handy. The officer did not check a suicide box on the booking form and he also failed to remove the young man's belt when placing him in a solitary cell. The decedent was found hanging about an hour later; he was cut down and survived with permanent brain damage and physical injuries.⁶⁶

The trial judge had refused the defendant's request for summary judgment after listening to a tape of the exchange with the booking

officer and finding a note of despondency in the youth's voice.⁶⁷ The Court of Appeals, however, with one dissent, held, "A single off-hand comment about shooting oneself when no gun is available cannot reasonably constitute a serious suicide threat."⁶⁸ The court held that the "off-hand" comment even as bolstered by the detainee's fitting a suicide profile cannot support the "strong likelihood of suicide" requirement for liability. At best, there is negligence here and summary judgment was ordered.⁶⁹

In another decision,⁷⁰ a life-threatening, domestic violence scene ended with the arrest of the plaintiff's paramour who was drunk at the time. The plaintiff told the arresting officer that earlier she heard the decedent say, "If I only had the guts." She interpreted that to mean, "If I only had the guts I would shoot myself with this gun." The plaintiff had told the arresting officer of her interpretation of the decedent's earlier words. The officer knew of the violence and intoxication, yet took no suicide precautions. Jail officials violated their own rules on cell monitoring and were disciplined for their dereliction in the wake of the decedent's suicide.⁷¹

The court, however, granted the defendants summary judgment, characterizing the earlier threat as a vague reference to suicide, analogous to the *Bell v. Stigers* "off-hand" comment about wanting a gun. The court seemed to vacillate between treating the decedent's reference to 'having the guts' either as an ambiguous suicide threat or a suicide threat that was reasonably clear but not actionable without any clear history of suicide attempts or suicide ideation.⁷²

*Kocienski v. City of Bayonne*⁷³ is yet another variation on the *Freedman* information-interpretation problem. Here, the plaintiff's sister, one Garity, was arrested and jailed on theft charges. About

ten hours thereafter she committed suicide, hanging herself with her panty hose.

The decedent had a history of contact with the defendant police department, including earlier information that she was suicidal and may have overdosed on drugs. Two weeks previously, the plaintiff obtained a restraining order to protect her from possible violence at the hands of her sister. The order had the word "psychiatric" clearly written on it. The plaintiff left the order with the police department and called the next day to make certain her sister's last name was on the order. The suicide occurred soon thereafter.⁷⁴

The court held that an officer's failure to discern suicidal tendencies from the face of the restraining order—i.e., the word "psychiatric"—was at most negligence. Referring to *Freedman*, the court stated, "The failure to recognize signs far more indicative of potential suicide than that which (the officer) 'failed' to recognize has constituted negligence only."⁷⁵

Thus, in the context of the deliberate indifference standard, the federal courts place only a nominal burden of information interpretation on the police and other custodial officials. The information aspect of the deliberate indifference test has yet other dimensions to which we soon turn.

d) Absence of Policy Not Necessarily a Defense for Individual Officer

On the question of suicide policy *vel non*, *Snow v. City of Citronelle*,⁷⁶ is of the opinion that the city could not be held liable merely because of the failure of the city to have a policy on suicide. All of the officers involved in a jail suicide case stated that there was an unwritten policy regarding suicidal detainees. Even more interesting was the court's insistence on a causal link between the absence of policy and the suicide at issue.

One officer, however, with direct knowledge of the detainee's suicidal propensities, stated what he would have done had he suspected a high risk of suicide and that those actions—a fifteen-minute watch, placement in a "safe" drunk tank—are all that would have been constitutionally required.⁷⁷

Thus, even though a jail suicide policy plainly is a good practice, when absent and personnel can be shown to have knowledge of constitutionally acceptable preventive steps, lack of such policy alone does not establish deliberate indifference. The officer with knowledge, but who failed to take the appropriate steps, would not prevail on summary judgment and remained open to a finding of liability.

3) No Passing or Sharing of Information—The "Hand-Off" Issue

Freedman includes one additional dimension. *Freedman* held that there was no constitutional duty imposed on a trained police officer to recognize large and prominent scars as "hesitation marks" and it also held that no liability attached due to the failure of the decedent's probation officer, who knew of *Freedman*'s prior suicide attempts, to inform the detective questioning the decedent.⁷⁸ Even

UPDATE ON THE INTERNET

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

www.ncianet.org/suicideprevention

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

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

www.ncjrs.org/html/ojjdp/jjnl_2000_4/sui.html

www.cimh.org/publications/publications.cfm

www.omh.state.ny.us/omhweb/forensic/suicide.htm

www.pbstandards.org/ResourceSection.aspx?id=4

if the officer was at the jail during the questioning and chose not to convey the information about suicidal tendencies, this did not amount to showing reckless indifference to Freedman's rights.⁷⁹

This aspect of *Freedman* relates to a continuing problem that I will characterize as a "hand-off" problem. Hand-off problems occur, for example, where there is a shift change and the incoming staff are not given suicide-relevant information by the outgoing shift; where an arresting or transporting officer has such information and does not pass it along; or where a known suicide risk simply moves through the conveyor belt of the criminal justice system and there is no intra- or interagency sharing of such information. The hand-off problem speaks directly to the now discarded "should have known" aspect of the deliberate indifference test: defendants knew or *should have known* of a particular vulnerability to suicide.

In *Lewis v. Parish of Terrebone*,⁸⁰ a most bizarre set of circumstances culminated in the suicide death of a man placed in isolation as punishment for striking a deputy who had driven him back to the jail after a mental examination at a hospital. Prior to the assault, the deputy placed an envelope containing the examining psychiatrist's advice on a desk near the defendant warden.⁸¹ The envelope remained unopened until Lewis was found dead. It contained a diagnosis that he was suicidal and the specific suicide precautions that should be taken. The warden actually knew other facts that were also strongly suggestive of suicide. The failure to inform himself, however, of an available medical opinion seemed most persuasive in upholding a jury verdict for Lewis' survivors.⁸²

*McDuffie v. Hopper*⁸³ is yet another example of the personal representative of a prisoner who committed suicide surviving a motion for summary judgment. The decedent, an Alabama prisoner for over seventeen years, had a long, documented history of hallucinations and at least four prior suicide attempts. Shortly before his death by a hanging while in an isolation cell, the decedent's actions and requests were strongly indicative of suicidal thoughts, yet the prison mental health specialists abruptly terminated his massive doses of Thorazine and provided no substitute or monitoring.⁸⁴

The plaintiffs charged CMS with discontinuing medication to cut costs.⁸⁵ Relying on the plaintiff's expert, a tactic that surprised the judge as much as it probably does the reader,⁸⁶ the court had little trouble finding sufficient evidence of deliberate indifference to escape a motion for summary judgment.⁸⁷

Thus, where there is clear and unequivocal information regarding a person's suicidal tendencies—and that information must relate to a clinical diagnosis, a fairly recent suicide attempt, or an unequivocal threat—and no special precautions are taken, plaintiffs have a fair chance to escape summary judgment and prevail before a jury. Where the suicide-relevant information is even slightly ambiguous, the courts tend to treat a failure to alert or a misinterpretation as negligence, at best.

In a decision from the Sixth Circuit Court of Appeals,⁸⁸ a Michigan inmate committed suicide by overdosing on his prescribed, psychotropic medication. The treating mental health professionals had medical records indicating the decedent's clinical depression and suicidal thought; they knew he had attempted suicide on

prior occasions (once by medication overdose); and they knew he had been placed on liquid medication and was severely depressed.⁸⁹ The majority rebuffed the defendants' attempt to characterize this claim as a failure to screen. Obviously, the events had moved beyond screening and a knowledge base existed equating with a high degree of risk.

The most damaging aspect of the defendants' position was the evidence that liquid medication (versus tablets) was not dispensed at pill call because "it would take a longer amount of time."⁹⁰ This surely sounds an alarm to all correctional mental health providers concerning the conduct of pill call. I often encounter hoarding by "cheeking" the pills because the nurse is rushed or harried; inmates may receive the wrong medication or wrong dosage; records are poorly maintained, and so on. Convenience simply cannot be the deciding factor in dispensing potentially lethal drugs. *Williams* certainly testifies to that fact.

What I have termed the information "hand-off" problem certainly is not clearly resolved by the reported decisions. In *Elliott v. Cheshire County, N.H.*,⁹¹ for example, a young man with a long history of mental health problems, and most recently diagnosed as schizophrenic, assaulted his mother. Trooper Ranhoff responded to the parents' call for police, and while he was told that the son had mental health problems and was schizophrenic, he was not told of the son's two prior threats to commit suicide.⁹²

The trooper, however, did not inform the intake officer of what he knew of the arrestee's mental illness, and the intake officer asked no questions on point. A few days later, after some very strange and suicide-suggestive behavior, the boy committed suicide while in custody. The reviewing court found that the trooper did not know of the decedent's prior suicide threats and that the boy's demeanor did not suggest suicide. The court simply ignored the fact that Ranhoff was given the boy's mental health information and knew of the diagnosis of schizophrenia.⁹³

Elliott seems to straddle the *Freedman* information-interpretation category and the hand-off category. Clearly, not every schizophrenic is a custodial suicide risk and not every narrative of mental health problems suggests a suicide alert. However, when an arresting officer has information of the sort possessed by Ranhoff and fails to hand it off to a booking officer, and where that officer asks no suicide screening questions, this surely is extremely poor practice. Whether it is deliberate indifference, of course, is another matter. Courts are inclined to label it negligence and, in so doing, once again give support to ignorance and dissembling.

4) Professional Evasion

With the courts tending to reward ignorance, a pernicious practice may be developing. A psychologist on contract to a jail informed me that when asked to do a work-up on an arrestee or a detainee, he will never use the word suicide in a report. He may order further tests, seek to obtain medication, or even prescribe a watch, but it will not be called a suicide watch. He has been led to believe that by using the word suicide he may be exposing himself and his colleagues to an easily avoided liability. Is he correct? In *Dobson v. Magnusson*,⁹⁴ an escapee was returned to prison and a sergeant placed the prisoner on a fifteen-minute suicide watch. A

psychologist then examined Dobson and found no indication of an intent to die although “he might engage in injurious behavior.”⁹⁵ He continued the fifteen-minute watch as a precaution. The requisite check-ups were not made and in that interim a distraught Dobson committed suicide. The court stated, “We agree with the district court . . . that it [missing two checks] could not be thought so faulty as to indicate indifference, deliberate or otherwise. If this watch had been . . . a suicide watch, we might feel differently . . .”⁹⁶

5) Risk and Causation Issues

*Hardin v. Hayes*⁹⁷ involved a decedent who (1) called police, (2) then kicked in the squad car door, and (3) was seen in jail the next day smearing vomit on herself, beating her head on the bars, and stabbing herself and an officer with a pen.⁹⁸ Following a mental health examination, as civil commitment papers were being drawn, she was observed putting her head under water in the sink, eating feces, falling down, and then collapsing and dying. She died from asphyxiation, having swallowed a small bar of soap and failing to dislodge it.

Hardin’s estate sued the city and a number of city and county officials. The sheriff and the Chief of Police settled on the first day of trial, and the jury returned a verdict for the city finding neither deliberate indifference nor negligence. The trial judge ordered a new trial; the city appealed; and the appellate court found that in ordering a new trial the trial judge abused his discretion.

We should note that the plaintiff abandoned the suicide claim during the trial, no longer asserting that the death was a suicide, and argued instead that the City was liable for Hardin’s anguish during confinement. With all this in mind, *Hardin* still leaves open a very interesting risk question. Assuming that the one and one-half day delay in obtaining treatment was unreasonable, one must still ask whether that delay was causally related to the risk of death by asphyxiation from the ingestion of soap. Apparently, the plaintiff’s medical expert uncovered only two self-inflicted jail deaths through ingestion of foreign objects in a sample of 400 deaths. The court of appeals found it reasonable for a jury to conclude that the delay in getting care was not unreasonable in light of the knowledge of harm.⁹⁹

Hardin, then, may be seen as a good teaching case from the standpoint of risk and causation analysis. That is, even where it is crystal clear that a detainee is very ill and destructive, if no care is provided and self-inflicted death ensues, the manner or instrumentability of death needs to be placed within the scope of the risk. For example, if Hardin had tripped and fallen in her cell and died from head injuries, one would have the same analytical problem.

Risks and Duties

1) Seriousness of Threat

In *Heggs v. Grant*,¹⁰⁰ the decedent was brought to jail drunk. After communicating initial denials during intake screening, Ms. Heggs then threatened to kill herself on learning she would be detained. She then retracted the threat, stating that she was only joking. She also refused an offer of hospital care. The lieutenant

directly involved with her had known the decedent for some fifteen years and indicated that he had not otherwise known her to be suicidal. This lieutenant placed Ms. Heggs in a cell by herself without a blanket, sheet, or mattress but left her with her clothing. The other items were removed as a safeguard against fire or property destruction.¹⁰¹ She was subject to fifteen-minute vision checks, which did occur, but she still managed to successfully hang herself with her socks. The federal court of appeals held that the law did not and does not require that defendants do anything more or differently. The officers’ evaluation of her risk potential and her overall situation required no further preventative action or training.¹⁰²

If the plaintiffs in *Heggs* hoped to prevail, they would have had to win the battle on the seriousness of the threat and somehow show that while the threat was serious, the recanting was not. Even with this showing, the plaintiff would also have had to show that the regular observation and clothing left with the decedent in the cell amounted to deliberate indifference.¹⁰³ This they failed to do, and

NATIONAL STUDY OF JAIL SUICIDES

Through a cooperative agreement with the National Institute of Corrections (NIC), U.S. Justice Department, the National Center on Institutions and Alternatives (NCIA) is currently conducting a national study on jail suicides. The 18-month project, representing the third such national study conducted by NCIA for NIC (e.g., see *And Darkness Closes: A National Study of Jail Suicides* in 1981 and the *National Study of Jail Suicides: Seven Years Later* in 1988), will determine the extent and distribution of jail suicides (i.e., city, county, and police department facilities) during 2005 and 2006, and gather descriptive data on demographic characteristics of each victim, characteristics of the incident, and characteristics of the jail facility which sustained the suicide. NCIA will then develop a report of the findings to be utilized as a resource tool for both jail personnel in expanding their knowledge base, and correctional (as well as mental health and medical) administrators in creating and/or revising policies and training curricula on suicide prevention.

Data provided by individual agencies/facilities will be coded and held in the strictest confidence. Results of the study will be presented in summary fashion, thus preventing the linkage of any data to the particular agency/facility from which the information originated.

Phase 1 surveys were distributed in 2007. Phase 2 surveys were distributed in early 2008. Both NIC and NCIA would greatly appreciate the cooperation of all agencies/facilities receiving the initial survey request. For further information on the project, please contact Lindsay M. Hayes, Project Director, NCIA, 40 Lantern Lane, Mansfield., MA 02048, (508/337-8806), e-mail: lhayesta@msn.com

indeed it would be difficult to do within the framework of the *Farmer* requirement of actual knowledge of an imminent threat to commit suicide.

2) Actual Knowledge

*Williams v. Lee Co. Alabama*¹⁰⁴ involved an obviously mentally ill detainee and a somewhat ambiguous threat to commit suicide. Once again, the defendants prevailed. Williams had sought to be detoxified at a medical facility but then left without authority. He was taken into custody by order of a probate court and taken to jail on a temporary “mental hold” pending the probate court hearing.¹⁰⁵ Jail officials had a probate court form stating that Williams was believed to be mentally ill and a present danger of substantial harm to himself, and that he recently left a hospital without authorization.

Williams was under constant observation for two days and then moved to a single cell where he was checked every fifteen or twenty minutes. An Officer Jones visited Williams in his cell and Williams said, “I’m not going to make it. If I don’t do it myself, somebody else will.” Jones left and reportedly reflected on this statement and then sagely concluded that it was a threat of self-harm. Whether Jones’s supervisors were told of this remains disputed but it is clear that fifteen or twenty minutes later Jones found Williams hanging by a sheet from a sprinkler in the ceiling. The federal appeals court affirmed summary judgment here finding no possibility of showing deliberate indifference. “A reasonable official would have no reason to assume from routine booking information that a prisoner brought with him a strong, or any, likelihood of suicide.”¹⁰⁶

This brief opinion made no mention of the need for mental health care while the decedent was in jail, and one may only presume that none was provided. The court did note that this was the first suicide at this jail and that William’s cell had specially constructed non-moveable furniture with the sprinkler head some ten feet from the floor.¹⁰⁷

It remains a mystery to me how this court could first recite the facts known to jail officials—the clear statement of mental illness and “dangerousness”—and then conclude that there was no reason to assume any likelihood of suicide. If the reference is somehow to the more limited information obtained in the routine booking process it may make a bit more sense, but it obviously does not matter how one characterizes the information—it was available and presumably known. The only substantial question should have been: given a clear risk of imminent self-harm or suicide, were jail officials deliberately indifferent in light of that information? Should there have been an immediate mental health intervention? Should there have been constant observation?

In *Olivas v. Denver*,¹⁰⁸ the decedent hung himself with leg irons that authorities had actually left on the bars of his cell. Officer Mitchell, with others, had responded to a domestic disturbance call in which the decedent’s girlfriend told them that the decedent was drunk, threatening violence, and was in the bathroom ready to cut his wrists. Blood drops were observed. Concerning Officer Mitchell, the court found there was enough evidence of actual

knowledge of suicide risk for the plaintiffs to escape summary judgment. The Chief of Police was found to have immunity without a showing that there had been a series of suicide attempts or knowledge of a serious risk of suicide in police substations.

This would seem to be a case in which actual knowledge of the risk is plain and the means of suicide closely linked to deliberate indifference. And yet, even here the defendants argued that the case should not even go to trial; and the right to a trial, it should be clear, is all that was won here.

*Domino v. Texas Dept. of Criminal Justice*¹⁰⁹ is yet another decision in which the record fairly screams “actual knowledge” and abandonment by the prison psychiatrist of his “at risk” inmate-patient. Once again, these cases are fact driven and require somewhat lengthy factual narratives to facilitate understanding. Antoine Domino committed suicide by hanging himself with a bed sheet in his prison cell at the Coffield Unit of the Texas Department of Criminal Justice (TDCJ) on August 2, 1996. Reddy was a psychiatrist at the Coffield Unit at the time of Domino’s suicide and had treated him on a number of occasions. On August 2, 1996, Domino asked to meet with a member of the Psychiatric Team at Coffield. He met with a prison psychologist Gayle Haynes, who then referred him to Reddy for further evaluation. Reddy’s evaluation of Domino lasted approximately five minutes.

During this meeting, Domino asked for sleeping pills and expressed apprehension about his upcoming transfer from administrative segregation to the general prison population. After Reddy denied his request for sleeping pills, Domino said, “I can be suicidal.” Reddy did not believe that Domino was a suicide risk at that time, thinking instead that Domino’s statement was an attempt to achieve a secondary gain such as sedatives or a single cell. Domino then began banging his head on the table and Reddy had the guards take Domino back to his cell. Two and one-half hours later, he committed suicide.

Domino had a long history of psychological problems. Even before being incarcerated, he was hospitalized for those problems and he also attempted suicide several times. Reddy did not start working at Coffield until January 1995. Domino was already an inmate at this time, but he was not sent to Reddy until March 1995, when Domino was found in his cell with a homemade noose. Reddy diagnosed Domino as suffering from recurrent major depression and started him on Prozac. The doctor also placed him back on the active psychiatric caseload and ordered weekly visits with a therapist.

In March 1995, Domino was transferred to Skyview Psychiatric Hospital for six days after he made more suicide threats at Coffield. At Skyview, he was diagnosed as suffering from bipolar (manic-depressive) disorder, with depression in full remission. In Domino’s discharge note, the Skyview physicians wrote that some of his behavior could be characterized as manipulative. When Domino returned to Coffield, Reddy examined him again and prescribed lithium to treat the bipolar disorder.

Reddy saw Domino in April 1995 for a routine follow-up appointment. Reddy continued Domino’s lithium and Prozac

because he continued to be depressed, and scheduled another follow-up appointment for June 1995. At this appointment, Reddy continued Domino's medications even though he refused to permit blood work that was necessary to monitor his lithium levels. Domino continued to refuse to permit this blood work.

In August 1995, Reddy discontinued both of Domino's medications, stating that Domino was not compliant and refused to permit the necessary blood work. Domino did not attend his scheduled counseling sessions in September and October 1995. In December 1995, the entire psychiatric team at Coffield, including Reddy, decided to release him from the active caseload. Their report stated that he was no longer expressing psychotic symptoms and would be seen only on request.

Domino was not examined again until June 1996, when he asked to see a psychiatrist. A member of the psychiatric team met with him and wrote in Domino's file that "suicidal ideation was present but no plan [was] evident." Domino scheduled another meeting with a therapist in July 1996, which he failed to attend. He next met with a member of the psychiatric team on the day of his suicide, as described above.

The plaintiffs presented an affidavit from Dr. Dennis Koson, a well-known expert in correctional psychiatry, stating that the five-minute evaluation and subsequent inaction amounted to a "virtual abandonment" of Domino. Other records show Domino as extremely depressed, feeling hopeless, and banging his head on the table loud enough that guards outside Reddy's office heard it.

In reversing, the Fifth Circuit stated in effect that it would not be permissible for a reasonable jury to conclude that Reddy knew that Domino was a serious suicide risk. The court was actually stating that nothing supported the subjective knowledge requirement aspect of deliberate indifference. Indeed, the court's unexpressed logic would seem to be that suicidal ideation and suicide attempts over time are more supportive of malingering—or its first cousin, secondary gain—than credible evidence of suicide risk.¹¹⁰ The formula at work here may be even more pernicious: the longer the duration of suicide threats, the less credibility to be attached to the threatener ("If he was really serious, he would have...").

The record supports a different result than the one reached: a seriously ill inmate, depressed, hopeless, taken off medication but not taken seriously. For this court to resolve the matter on summary judgment is almost beyond the pale.

3) Professional Judgment Issues

Estate of Max G. Cole v. Fromm,¹¹¹ discussed earlier in this chapter, raises some interesting issues. In this case, the detainee committed suicide while hospitalized by placing a plastic bag used as the liner for a clothes hamper over his head and suffocating to death. This detainee was reporting suicidal thoughts, but apparently they were not couched in terms of present intention. The decedent was on a suicide precaution watch, but not a close watch, based on medical judgment. This form of suicide—using a bag from a clothes hamper liner—had never before been encountered at this hospital, and there was evidence that it generally was very rare in custodial suicides.

Are we able to say that there was a risk of suicide, based on the decedent's words, and that the use of plastic bags in an area accessible by patients on suicide watch represented a suicide risk as to the means employed? The answer would appear to be yes. However, the Seventh Circuit Court of Appeals was concerned with a "strong likelihood" versus a "mere possibility" and in the use of this measure of probability, the court joined the requirement of a high risk of the event with a high risk regarding the means employed. That there is "some risk" did not require the adoption of all preventive measures, according to the court.¹¹²

The court relied on *Youngberg v. Romeo*¹¹³ first to set up, and then to resolve, important policy disputes. The initial question here relates to the significance of the exercise of medical, or professional, judgment. A doctor concluded that the decedent was not a high risk of suicide, with the very restrictive precautions attendant to that decision.¹¹⁴

An expert for the plaintiffs was prepared to disagree both as to the risk of suicide and the risk attendant to access of the plastic bag actually employed. Relying on *Romeo*, the court stated: "[D]eliberate indifference may be inferred based upon a medical professionals' erroneous treatment decision only when the medical professional's decision is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible did not base the decision on such a judgment."¹¹⁵

This effectively precludes reliance on another, basically opposed, medical opinion even if other experts would, in a sense, vote with the latter opinion. Courts view this as a mere disagreement of professional judgment, with correctional (or here, hospital) authorities able to rely on the sole, contrary view so long as professional judgment was exercised.

The second use of *Romeo* here relates to the policy issue of personal freedom versus bodily restraint to prevent death. Noting that detainees have a limited right to avoid personal restraint¹¹⁶ and a right to avoid injury, the court stated:

When faced with treatment of an individual in state custody, a medical professional must consider conflicting rights. Cole had a right to be free from restraint, but this right was not absolute; it ended at the point at which his freedom of restraint posed the substantial risk that he would seriously injure or kill himself. At that point, Cole had a right to appropriate treatment, including bodily restraint. Where these conflicting medical rights intersect is a matter of medical judgment. In making this judgment, the medical professional must balance the need for treatment against competing concerns—i.e., preventing unnecessary treatment, the need for freedom from unnecessary restraint, etc. Surely, if defendants bound, gagged, and immobilized like Hannibal Lecter every patient for the sole purpose of preventing the patients from injuring themselves, then Cole would not have been able to access the plastic bags. At the same time, however, defendants would have violated Cole's right to be free from bodily restraint because the doctor would have failed to exercise medical judgment. *Youngberg* and *Farmer* both

require medical professionals to exercise medical judgment. The right to be free from bodily restraint is breached when an individual is restrained unless the decision was made pursuant to an appropriate exercise of judgment by a health professional. If the decision is made by a professional, it is presumptively valid. We find that the same standard applied to allegations of improper medical treatment as evidence of “deliberate indifference.”¹¹⁷

In *Cole*, the issue of duty to provide a safe environment focused on the availability of the plastic bags. Some of the defendants conceded that they knew such bags could be used to commit suicide and all of the nursing defendants admitted they would have confiscated a plastic bag from Cole if they had seen him obtain it, which they did not.¹¹⁸

Regarding the possibility of deliberate indifference on the safety issue, the court stated:

There is no evidence, however, that any defendant perceived the presence of the plastic bags in the BU2 unit to be a danger to Cole or other patients. In addition, no person who had worked in the BU2 unit, visited it, or inspected it had ever recognized that the bags posed a risk to the patients and no person had called such risk to the Hospital’s attention. Finally, there was no evidence that any BU2 unit patient had ever tried to harm himself or herself with a plastic bag prior to Cole’s suicide.¹¹⁹

Cole, then, is not a case about the failure to obtain relevant information, nor is it about having some information that actually indicates prior suicide attempts (e.g., scars on the wrists)¹²⁰ but is not interpreted properly. This is a case in which the decedent was believed to be a suicide risk *and* the accessible implement used to commit suicide was believed to be an object that is dangerous in the hands of a suicidal person. Why then was summary judgment for the defendants affirmed?

Expert opinion existed to the effect that the risk was not “serious”—meaning imminent, in my view—and that while the bags were dangerous, the danger factor relates to the imminence of the danger of suicide. If this sounds rather strained, it is a view shared with this author.

Indeed, I find the entire analysis by the *Cole* court flawed, and especially so in denying the plaintiffs an opportunity for a trial by a jury. If professional judgment, as here, is used to trump compelling evidence supportive of deliberate indifference, then the possibility of recovery in such cases becomes even more illusory.¹²¹ The professional judgment standard as used in *Cole* becomes a proxy for the older “hands-off” doctrine and substitutes a concern with who decides for the more substantive basis of how the decision is made.¹²²

Post-Suicide Attempt Duties

A model suicide prevention policy speaks clearly to what should be done when correctional staff approach 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.¹²³

Model rules or best practices, however, do not always coincide with the relevant legal rules. *Dispace v. Goord*¹²⁴ 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 Judge 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 and a nurse. Qualified immunity serves as a defense where the constitutional right at issue is 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 Department of Correctional Services (DOCS). He was last seen alive in his cell at 4:32 A.M. on August 10, 1999. Correctional Officer Krause found the decedent hanging from a sheet in his cell at 4:47 A.M. 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 carotid 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.”

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 thirty 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.”¹²⁵

Other courts of this era appear to have accepted that a good faith belief that an inmate was already dead excused efforts to revive. At the worst, the failure 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.

Correctional Officer Skinner is 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 is 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.

As was true for Krause and Skinner, the only evidence in the record is that Nurse Murphy believed that Tortorici was dead based on her evaluation of him. Perhaps as a predicate for the belief that Nurse Murphy harbored ill will towards inmates, the plaintiffs argued that Murphy had a personal policy against administering CPR to prisoners. However, the deposition testimony plaintiffs relied on for this predicate demonstrates that while 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.”

The plaintiffs argued that Nurse Murphy violated a DOCS directive in failing to commence CPR. The policy requires “First Responders” to “immediately” commence CPR on “any person found unresponsive and without pulse or respirations.” The court found that the violation of this stated policy did not provide a basis for finding that there was a violation of the Federal Constitution.

In summing up, the court stated:

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.¹²⁶

Obviously, today it is the far better practice to follow the model policy provision quoted above. Do not confuse what might seem to be a vain act with what is now almost certainly a legally required act.¹²⁷

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. Such cases likely will be the most egregious and difficult to defend. In repeatedly making my “it’s difficult to win” statement, I do not mean to 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 many of the cases discussed here.

Footnotes

¹Where the Fourth Amendment is used as a basis for liability, a reasonableness test might apply (as discussed above).

²511 U.S. 825 (1994).

³501 U.S. 294 (1991).

⁴429 U.S. 97 (1976).

⁵489 U.S. 378 (1989).

⁶There are cases dealing with a claim of inadequate aid after a suicide has been attempted. While such a claim may argue that life could have been saved, it is not focused on prevention of the suicidal act. See, e.g., *Estate of Cartwright v. City of Concord, Calif.*, 856 F.2d 1437 (9th Cir. 1988), also involving an unsuccessful claim of inadequate post-hanging investigation and preservation of evidence.

⁷*Wychoff v. Mutual Life Ins. Co.*, 147 P.2d 227, 229 (1944). At common law, suicides were punishable by ignominious burial and forfeiture of chattels. A widely held belief that mental illness “caused” suicide probably accounts for its gradual legal destigmatization. See Kate Bloch, “The Role of Law in Suicide Prevention: Beyond Civil Commitment—Bystander’s Duty to Report Suicide Threats,” 39 *Stanford L. Rev.*, 929 (1989). See also Stephen Morse, “A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered,” 70 *Calif. L. Rev.*, 54, 59–65 (1982),

- arguing generally that the assertion that the crazy behavior of mentally disordered persons is compelled, in contrast to the freely chosen behavior of normal persons, is a belief based on common sense assumptions and not on scientific evidence.
- ⁸See Sam Brakel, John Parry & Barbara Weiner, *The Mentally Disabled and the Law* 3d. ed. (American Bar Foundation, 1985), Ch.2. This is the single best reference book available on the mentally ill and the law.
- ⁹ David Wexler, *Mental Health Law: Major Issues* (1981), pp. 45-47.
- ¹⁰423 F.Supp.2d 882 (E.D. Wisc. 2006).
- ¹¹423 F.Supp.2d at 890 (citations omitted).
- ¹²423 F.Supp.2d at 897.
- ¹³See Fred Cohen, *The Law of Deprivation of Liberty* (1991), pp. 107-122, for various perspectives on treatment.
- ¹⁴Robert Rubenstein, Rafael Meses & Theodore Lidz, “On Attempted Suicide,” 79 *AMA Archives of Neurology & Psychiatry*, 103, 111 (1958), conclude that attempted suicide is not an effort to die but rather an effort to improve one’s life. Anecdotal evidence I have acquired suggests that some, perhaps many, threats or attempts at custodial suicide are either pleas for help or a manipulative effort to obtain a mental health placement that would not otherwise be available. When asked for legal advice on point I always urge that errors be made on the side of taking the threat or aborted effort seriously.
- ¹⁵175 F.3d 1019 (7th Cir. 1999).
- ¹⁶Id.
- ¹⁷*Supra* note, F.3d at 850.
- ¹⁸45 F.3d 1310, 1314 (9th Cir. 1995).
- ¹⁹*Davis*, *supra* note 18.
- ²⁰Lindsay Hayes, “Suicide Prevention and ‘Protrusion-Free’ Design of Correctional Facilities,” 12 *Jail Suicide/Mental Health Update* 1 (Fall 2003).
- ²¹Hayes, *supra* note 20.
- ²²*Supra* note 20.
- ²³*Supra* note 20, p 2.
- ²⁴925 F.Supp. 1374 (N.D. Ill. 1996).
- ²⁵*Viero*, 925 F.Supp. at 1382 n.18.
- ²⁶228 F.3d 388 (5th Cir. 2000).
- ²⁷Liability for custodial suicide based on design defect alone is a virtual impossibility.
- ²⁸See ¶ 14.4[3].
- ²⁹*Jacobs*, *supra* note 26, 228 F.3d at 394.
- ³⁰*Supra* note 10.
- ³¹*Supra* note 10, 423 F. Supp.2d at 891 et seq.
- ³²*Zwalesky*, 749 F.Supp. 815 (W.D. Mich. 1990).
- ³³*Zwalesky*, *supra* note 32, 749 F.Supp. at 818.
- ³⁴*Zwalesky*, *supra* note 32, 749 F.Supp. at 819. This proposition—no duty to screen—is now seriously in doubt. See Christy P. Johnson, “Mental Health Care Policies in Jail Systems: Suicide and the Eighth Amendment,” 35 *U.C. Davis L. Rev.* 1227, 1231, 1254 (2002), which argues persuasively for intake screening as to suicide potential and for a professional evaluation before an inmate may be removed from suicide precautions.
- ³⁵See Fred Cohen, “Custodial Suicides: Common Source of Litigation—But Cases Can Be Defended” in *I Corr. L. Rep.* 50 (1989).
- ³⁶*Zwalesky*, *supra* note 32, 749 F.Supp. at 820.
- ³⁷In *YellowHorse v. Pennington Co.*, 225 F.3d 923 (8th Cir. 2000), an alcoholic with a recent suicide attempt and serving a thirty-day DUI sentence committed suicide in jail by hanging. He was placed on suicide watch three times, was removed each time without consultation with a clinician, and this was held not to constitute deliberate indifference.
- ³⁸898 F.2d 32 (4th Cir. 1990)
- ³⁹*Belcher*, *supra* note 38, 898 F.2d at 34-35.
- ⁴⁰See *Wilkes v. Borough of Clayton*, 696 F.Supp. 144 (D.N.J. 1988), discussed at 1 *Corr. L. Rep* 14 (1989) (decisions on automatic strip searches are noted).
- ⁴¹George J. Franks, in “The Conundrum of Federal Jail Suicide Case Law Under Section 1983 and It’s Double Bind for Jail Administrators,” 17 *L. & Psychology* 117, 132 (1993), views the double bind as the dilemma regarding screening and obtaining knowledge that may support deliberate indifference. As a former attorney for a sheriff’s department with a jail, the author urges that detainees be screened for suicide potential and then act accordingly.
- ⁴²See Fred Cohen, *supra* note 11, pp. 325-338, for a collection of material questioning the ability of “experts” to predict dangerousness. See *Foucha v. Louisiana*, 504 U.S. 71 (1992), on the issue of confining the non-mentally ill but dangerous offender.
- ⁴³I mention “health” because there are cases in which a suicide attempt is foiled, but not before serious and permanent brain damage occurs. See, e.g., *Rich v. City of Mayfield Heights*, 955 F.2d 1092 (6th Cir. 1992) (no right to be cut down immediately when discovered hanging, with delay resulting in physical and mental disabilities).
- ⁴⁴One cost is related to the additional demand on security manpower if an officer is required to engage in a close watch—let us say every fifteen minutes—and is then unavailable for other duties. If a constant watch is required, the demand is even more obvious.
- ⁴⁵*Supra* note 2.
- ⁴⁶853 F.2d 1111 (3d Cir. 1988).
- ⁴⁷*Freedman*, 853 F.2d at 1116. In *Payne v. Churchich* decedent’s tattoo questioned life, he was very drunk and cursed, and he was found asleep under a car. Without a record showing suicidal tendencies, with no evidence of past attempts or warning from others, and with no allegations of increasingly bizarre behavior, the court held that there was no reason for the deputy to suspect a substantial risk of suicide. In other words, tattoos do not talk.
- ⁴⁸*Id.* Judge Brotman may not have realized that his legitimate interest in training as a basis for establishing awareness may not, shall we say, provide a positive inducement to train on suicide prevention.
- ⁴⁹*Supra* note 2; See also *Mullins v. Stratton*, 878 F.Supp. 1016, 1021 (E.D. Ky. 1995) (failure to recognize a scar as evidence of a prior suicide attempt was not deliberate indifference).
- ⁵⁰2000 WL 964746 (E.D. Pa.) (not otherwise pub.).
- ⁵¹*Supra* note 5.
- ⁵²See *Zinnerman v. Burch*, 494 U.S. 113 (1990), for the proposition that foreseeable risks (here, that “voluntary” patients may not be competent) call for protective processes.

⁵³67 F.Supp.2d 686 (S.D. Tex. 1999).

⁵⁴*Smith*, 67 F.Supp.2d at 689.

⁵⁵*Id.*

⁵⁶6 F.Supp.2d 373 (E.D. Pa. 1998).

⁵⁷*Owens*, 6 F.Supp.2d at 375-377 (citations omitted).

⁵⁸*Supra* note 2.

⁵⁹*Owens*, 6 F.Supp.2d at 380.

⁶⁰Indeed, the threat of self-harm seems unquestionably to be taken as the equivalent of a suicide threat. The judge did not engage in any semantic analysis and for the purposes of the motion equated self-harm with a serious suicide threat.

⁶¹*Owens*, *supra* note 56, 6 F.Supp.2d at 386.

⁶²*Supra* note 5.

⁶³*Owens*, *supra* note 56, 6 F.Supp.2d at 392.

⁶⁴But see *Brewer v. City of Daphne*, 1999 U.S. Dist. LEXIS 2056, at *1 (Jan. 28, 1999), where summary judgment in a jail suicide case was upheld despite the decedent's intoxicated state and discovery of a noose. The challenge of inadequate training, inter alia, failed. In *Ellis v. Washington Co. & Johnson City, Tenn.*, 198 F.3d 225 (6th Cir. 1999), a city jailer conceded he falsified his file as to his attendance at suicide prevention training. The decedent was in a delirious, delusional state while attempting to break into his psychiatrist's home, which also was the home of his girlfriend; he was known to be taking Klonopin and was recognized by an officer as the person that officer took to a psychiatric hospital a month earlier. Over a ringing dissent, summary judgment was upheld. In *Myers v. Oklahoma County Bd. of County Comm'rs*, 151 F.3d 1313, 1318 (10th Cir. 1998), a police shooting case, the court acknowledged the strength of the failure to train claim, but the county produced voluminous training materials relating to the mentally ill and also showed that the officers involved in the shooting received training in this area. The decedent was suicidal and shot to death in his apartment when he appeared to resist a court order to be taken into "protective custody."

⁶⁵937 F.2d 1340 (8th Cir. 1991).

⁶⁶*Id.*

⁶⁷*Bell v. County of Washington, Iowa*, 741 F.Supp. 1354, 1359 (S.D. Iowa, 1990).

⁶⁸*Bell v. Stigers*, *supra* note 65, 937 F.2d at 1344.

⁶⁹*Id.*

⁷⁰*Christian v. Stanczak*, 769 F.Supp. 317, 319 (E.D. Mo. 1991).

At the time of the threat, the decedent did have a weapon.

⁷¹*Christian*, 769 F.Supp. at 322.

⁷²*Id.*

⁷³757 F.Supp. 457 (D.N.J. 1991).

⁷⁴*Kocienski*, 757 F.Supp. at 460.

⁷⁵*Kocienski*, 757 F.Supp. at 464. This decision has other aspects as well, such as the violation of police rules in failing to remove panty hose.

⁷⁶420 F.3d 1262 (11th Cir. 2005).

⁷⁷*Snow*, *supra* note 76, 420 F.3d at 1271.

⁷⁸*Freedman*, *supra* note 46, 853 F.2d at 1117.

⁷⁹*Id.*

⁸⁰894 F.2d 142 (5th Cir. 1990).

⁸¹*Lewis*, 894 F.2d at 144.

⁸²The jury awarded no compensatory damages and only \$6,279.00 punitive damages, the cost of the funeral. The Court of Appeals remanded for further findings on damages. 894 F.2d at 150.

⁸³982 F.Supp. 817 (M.D. Ala. 1997).

⁸⁴*McDuffie*, 982 F.Supp. at 820.

⁸⁵CMS, perhaps the largest private mental health care provider to corrections, had the statewide contract for prison mental health services.

⁸⁶*McDuffie*, *supra* note 83, 982 F.Supp. at 827.

⁸⁷There was also evidence of failure to contact doctors who previously treated the decedent, that the cell housing the inmate increased the severity of the mental illness, and that there simply was no rationale for reducing (or eliminating) the medication.

⁸⁸*Williams v. Mehra*, 135 F.3d 1105 (6th Cir. 1998).

⁸⁹*Williams*, 135 F.3d at 1107-1113.

⁹⁰*Williams*, 135 F.3d at 1113 n.6.

⁹¹940 F.2d 7 (1st Cir. 1991).

⁹²*Elliott*, 940 F.2d at 9.

⁹³*Elliott*, 940 F.2d at 12. The case was remanded on possible liability for jail officials based on post-confinement behavior of the decedent. See also *Hare v. City of Corinth*, 74 F.3d 633 (5th Cir. 1996), in which there is a dispute concerning transmission of suicide-relevant information during a shift change at a Mississippi jail.

⁹⁴923 F.2d 229 (1st Cir. 1991).

⁹⁵*Dobson*, 923 F.2d at 230.

⁹⁶*Dobson* 923 F.2d at 231. Judgment for all defendants was affirmed. The decision was not clear concerning whether there was a significant difference between a "watch" and a "suicide watch."

⁹⁷52 F.3d 934 (11th Cir. 1995).

⁹⁸*Hardin*, 52 F.3d at 937.

⁹⁹*Hardin*, 52 F.3d at 940.

¹⁰⁰73 F.3d 317 (11th Cir. 1996).

¹⁰¹A cynic might suggest that this is very convenient testimony, akin to a mental health professional requesting only a watch. Testimony that the cell was stripped because of a concern for suicide would have elicited: "And if you thought her to be at risk for suicide, why not a constant watch? Why leave her with clothes that could be used for hanging?"

¹⁰²*Heggs*, 73 F.3d at 320.

¹⁰³The plaintiff's best argument would have been that constant observation was required and would have been preventative. Removal of clothing, except for a belt and shoelaces, is not usually recommended.

¹⁰⁴78 F.3d 491 (11th Cir. 1996).

¹⁰⁵This process is not unusual, since the local jail may be the only readily available custodial facility for persons who are homeless or dangerous and facing a commitment hearing. The reference to *Williams* as a "detainee" is a bit of a stretch but serves to distinguish him from a convicted inmate.

¹⁰⁶*Williams*, 78 F.3d at 493.

¹⁰⁷Of course, without knowing how easy it was to access the sprinkler head, presumably by standing on the furniture, these points are not very helpful. That this is the first suicide in this jail is relevant, but it is not determinative of liability on facts such as those in *Williams*. *Id.*

¹⁰⁸929 F.Supp. 1329 (D. Colo. 1996).

¹⁰⁹239 F.3d 752 (5th Cir. 2001).

¹¹⁰See Lindsay M. Hayes, "Suicide Prevention And Manipulative Behavior" and Greg E. Dear, Donald Thomson & Adelma M. Hills, "Self-Harm in Prison: Manipulators Can Also Be Suicide Attempters," 10 *Jail Suicide/Mental Health Update* 2 (2001), concluding that prison staff cannot assume that prisoners who appear, or even report, manipulation are not also suicidal when inflicting injury on themselves.

¹¹¹941 F.Supp 776 (S.D. Ind. 1995), aff'd, 94 F.3d. 254 (7th Cir. 1996).

¹¹²*Cole*, 94 F.3d at 260.

¹¹³457 U.S. 307 (1982). See Chapter 6, ¶ 6.2[4], and Chapter 7, ¶ 7.2[5][c], regarding *Romeo* and issues of professional judgment and staff training.

¹¹⁴*Cole*, supra note 111, 94 F.3d at 257.

¹¹⁵*Cole*, supra note 111, 94 F.3d at 262.

¹¹⁶*Id.* The court failed to note that this aspect of *Romeo* requires an analysis as to whether or not a detainee is being punished.

¹¹⁷*Id.* (citations omitted).

¹¹⁸*Cole*, supra note 111, 94 F.3d at 258.

¹¹⁹*Id.* The BU2 unit is, of course, the unit where the suicide occurred.

¹²⁰See *Mullins v. Stratton*, supra note 49, 878 F.Supp. at 1020.

¹²¹Other decisions in suicide that utilize the professional judgment standard are *Zwalesky v. Manistee Co.*, Mich., supra note 36, 749 F.Supp. at 819; *Danese v. Asman*, 875 F.2d 1239, 1243 (6th Cir. 1989) cert. denied, 494 U.S. 1027 (1990).

¹²²"Hands-off" is simply a way to describe a judicial policy of deference to various decision-makers. It attaches an almost impenetrable presumption of correctness, for example, to the decisions of doctors, wardens, sheriffs, police officers, and the like. For an excellent analysis of these matters, see Susan Stefan, "Leaving Civil Rights to the 'Experts'; From Defense to Abdication Under the Professional Judgment Standard," 102 *Yale L.J.* 639 (1992).

¹²³13 *Jail Suicide/Mental Health Update*, § F7 (Spring 2005). Other Model sections address emergency response equipment, notification procedures, and appropriate procedures depending on the security level of the housing unit.

¹²⁴308 F.Supp.2d 274 (S.D.N.Y. 2004).

¹²⁵308 F.Supp.2d at 284.

¹²⁶308 F.Supp.2d at 288

¹²⁷The court reviewed a number of interesting decisions on point, reproduced here 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.App. 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. Chicago*, 413 F.3d 688 (7th Cir. 2005), there were futile efforts at resuscitation, unacceptable delay in getting medical help, and a likely cover-up of pre- and post-suicide events. □

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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