JAIL SUICIDE UPDATE

JAIL SUICIDE PREVENTION INFORMATION TASK FORCE

LITIGATION

Suicide prevention in our nation's jails takes many forms. Ironically, chief among them is litigation. As the number of jail suicides increase, so do the number of lawsuits. Ten years ago, it was unusual for a jail to be sued for negligence following a suicide. Today, it is unusual if a suit is not filed. And while at the same time that both state and federal courts are making it increasingly difficult to hold public officials, jail administrators and their personnel liable for a jail suicide, these same courts are requiring a higher standard to operate a constitutional jail facility. Further, as with most litigation, the vast majority of jail suicide cases culminate in out-of-court settlements in sums ranging from $24,000 to $2.4 million. Such cases also usually result in improved jail conditions. Litigation has, therefore, played a significant role in jail suicide prevention.

The primary vehicle for most jail suicide litigation is Title 42, United States Code, Section 1983. This statute, which is called "Civil Action for Deprivation of Civil Rights" provides that:

"Every person who, under color of any statute, ordinance, regulation, custom, or usage of any State, Territory, or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or proper proceeding for redress."

Such litigation normally alleges violations of one or more of the rights guaranteed in the United States Constitution. The rights most commonly identified are: false arrest and/or imprisonment, cruel and unusual punishment, excessive use of force, due process of law, and equal protection. In jail suicide litigation, it would seem rather simple to state a claim of negligence based upon the deprivation of any of these rights. Plaintiffs have been successful in some cases filed in state courts on negligence grounds. See e.g., ***Lavigne*** v. ***Allen***, 36 A.D.2d 981, 321 N.Y.S.2d 179 (1971); ***Gioia*** v. ***State***, 22 A.D.2d 181, 254 N.Y.S.2d 384 (1964); ***Becker*** v. ***Beaudoin***, 261 A.2d 896 (R.I. 1970). However, in civil rights actions, there is controversy over whether negligence on the part of jailers which causes the death of an inmate states a cause of action under Section 1983. Compare ***Hirst*** v. ***Gertzen***, 676 F.2d 1252 (9th Cir. 1982), and ***Pantoja*** v. ***City of Gonzales***, 538 F. Supp. 335 (N.D. Cal. 1982), with ***Meshkov*** v. ***Abington Township***, 517 F. Supp. 1280 (E.D. Pa. 1981). See also ***Soto*** v. ***City of Sacramento***, 567 F. Supp. 662 (E.D. Cal. 1983).

Courts have recently ruled that mere negligence is an insufficient claim under Section 1983, and have required a showing of gross negligence or "deliberate indifference" to the need for precautions against suicide. The deliberate indifference standard, first utilized in ***Estelle*** v. ***Gamble***, 429 U.S. 97 (1976), is applicable to plaintiff claims of denial of medical care and other failures to protect their health and safety. One prominent example of the deliberate indifference standard usage in jail suicide litigation is ***Partridge*** v. ***Two Unknown Police Officers***, 751 F.2d 1182 (5th. Cir. 1986). The court ruled that the deliberate indifference standard is met only if there is a strong likelihood, rather than a mere possibility, that failure to provide care would result in harm to the prisoner. The court also stated that a strong claim to deliberate indifference can also be made by revealing a "pattern" of neglect.

Addressing the deliberate indifference standard, two recent Supreme Court decisions have stated that there is no liability under Section 1983 for negligent acts by officials which result in unintended injuries to life, liberty or property. In ***Davidson*** v. ***Cannon***, U.S. , 106 S. Ct. 668 (1986), the Court held there was no liability under Section 1983 where prison officials had failed to take steps to protect a prisoner who had notified them that the had received a threat from another inmate. The Court

INSIDE

SPRING 1987

characterized the lack of due care by the officials as simple negligence, and held that no procedure for compensation was constitutionally required by the due process clause. The opinion followed the Court's decision in ***Daniels*** v. ***Williams***, U.S. , 106 S. Ct. 662 (1986), where the Court denied relief under Section 1983 to a prisoner who sought damages from a fall on a prison stairway. ***Davidson*** has been applied to deny plaintiffs relief under Section 1983 in other contexts where a failure-to-protect claim based on negligence has been made.

It seems implicit from these decisions that mere negligence, or inadvertent failure to protect a detainee's health and safety, does not rise to the level of a constitutional violation, and that a heightened standard of culpability is required in civil rights litigation in general, and jail suicide cases in particular. As previously stated, documentation of a pattern of failure can rise to the deliberate indifference standard.

Plaintiffs will attempt to establish that the alleged violation(s) was not the result of a single event, but represented a continuing pattern of misconduct. Often, prior suicides and/or non-compliance with state/national standards will be utilized in the plaintiff's argument. "Although failure to comply with nonenforceable, recommended standards may not be a prima facie basis for liability, evidence of the existence of such standards is admissible to show a knowledge of existence of risk and a measure of actions of a reasonable man, or of custom." (***Falkenstein*** v. ***City of Bismarck***, 268 N.W. 201 2d 787 (N.D. 1978)). In addition, claims of gross negligence or deliberate indifference have also been associated with a "policy or custom" in jail suicide litigation.

The phrase of "policy or custom" gained prominence under ***Monell*** v. ***New York City Department of Social Services***, 436 U.S. 658 (1978), when the Supreme Court ruled that municipal liability may only be imposed for unconstitutional actions that are inflicted pursuant to a government policy or custom. In such cases, according to Michael Avery and David Rudovsky of the National Lawyers Guild, plaintiffs must prove two things:

"First, it must be established that the inaction is due to municipal policy or custom. What constitutes a 'policy' or 'custom' varies among the different lower federal courts. Where the city council or similar body has formally enacted an official policy in explicit terms there is little difficulty. However, the more common situation is that no such formal action has taken place, and the question is, Under what circumstances may a policy be inferred from the actions or inaction of municipal employees at the policy-making level, or from the inaction of the governing body itself?. . .After establishing a policy or custom based on a failure to correct unconstitutional conditions, the plaintiff must show that the violation of rights was a reasonably foreseeable consequence to the inaction, i.e., that the failure to act was the proximate cause of the violation. Expert testimony can be instrumental in establishing liability in such cases and in cases based on a theory of inadequate training and supervision."

In jail suicide litigation, plaintiffs will argue that maintaining (in addition to inadequate training and supervision) deficient jail conditions, overcrowding, insufficient staff, and a lack of written rules and procedures to screen and monitor potentially suicidal detainees fall within the purview of "policy or custom." (In ***Anderson*** v. ***City of Atlanta***, 778 F.2d 678 (11th Cir. 1985)), the court held that a conscious decision by city officials not to increase jail staff, when officials knew that failure to do so would impair the delivery of proper medical care to detainees, constituted a "policy" for purposes of establishing municipal liability. Further, in ***Anela*** v. ***City of Wildwood***, 790 F.2d 1063 (3d Cir. 1986), the court ruled that the longstanding practice of maintaining inadequate jail facilities constituted a city custom or usage.) Defendants will claim that such violations constitute "negative" policies, and, therefore, are insufficient to support a ***Monell*** claim of governmental liability. The Supreme Court will determine this year whether "negative" policies state a claim against a municipality under Section 1983. (See ***Kibbe*** v. ***City of Springfield***, 777 F.2d 801 (1st Cir. 1985), cert. granted, U.S. , (1986)).

Despite the varying interpretations, however, most experts agree that liability can be neutralized by a "pro-active" stance by municipalities and their respective jail administrators. In jail suicide litigation, a prevention program (with accompaning written rules and procedures) is critical, and includes: staff training, intake screening, classification, and increased monitoring. Such a program, coupled with compliance with state jail standards and working knowledge of "state of the art" prevention measures and national standards, will sufficiently thwart successful litigation. As Paul Embert has written: "As more and more jail administrators use the implications of correctional law to become pro-active managers who document their problem, develop adequate policies and procedures, and initiate visible training programs, those who cling to the old philosophies will assuredly become more and more at risk in civil court actions."

REFERENCES

Avery, Michael and David Rudovsky. ***Police Misconduct: Law and Litigation***, New York, New York, Clark Boardman Company, Ltd., Revised 1987.

Embert, Paul S. "Correctional Law and Jails," in David Kalinich and John Klofas (Eds.) ***Sneaking Inmates Down the Alley***, Springfield, IL, Charles C. Thomas, Publisher, 1986.

Miller, Rod (Ed.) "Prisoner Suicide — Caselaw and Standards," ***Detention Reporter***, Number 30, April, 1986.

SELECTED COURT CASES

Listed below are summaries of selected court cases relating to jail suicide litigation and corollary issues.

Falkenstein v. ***City of Bismarck***, 268 N.W. 2d 787 (N.D. 1978). Kevin Falkenstein was involved in a motor vehicle accident in Bismarck, North Dakota, and was arrested at the scene for driving while intoxicated. He was taken down to the Bismarck police station, where he was unable to post bond and was held in the city jail. After being moved to a cell, he "foul-mouthed" a Bismarck police officer and was placed in "the hole," a small cell which contained only a toilet bowl and had four solid walls. At 9:00 a.m. of the morning following his arrest, Falkenstein was found hanging from the door cell bars with his T-shirt knotted around his neck. A suit was brought to recover damages for Falkenstein's alleged wrongful death and an alleged violation of his civil rights.

The defendants in the case were a police sergeant and the City of Bismarck. The jury returned a verdict against the city on the wrongful death count in the amount of $25,000. The jury also found the police sergeant liable for violating Falkenstein's civil rights, assessing actual damages of $25,000 and punitive damages of $6,000.

In discussing the merits of the case, the North Dakota Supreme Court stated that before a sheriff or city could be held liable for the death by suicide of an inmate, the plaintiff must first demonstrate that: (1) the death was foreseeable; and (2) special circumstances existed which imposed upon the jailer a duty to protect the inmate from his own intentional conduct.

Ruling on the foreseeability issue, the court stated:

"Witnesses for the City acknowledged that there is a rule that each prisoner is required to remove his belt, shoelaces, and necktie prior to being placed in a cell. The purpose of the rule is to prevent the prisoner from harming himself. Former Chief of Police Kern acknowledged that one reason for maintaining 'visual and hearing observation' of the prisoner 'is an effort to try and avoid injury to prisoners, either accidental or self-inflicted.' Upon this evidence alone, the jury could conclude that Kevin (Falkenstein's) death was foreseeable."

In regard to the special circumstances requirement, the court stated that Falkenstein's intoxication at the time of his incarceration "can provide the special circumstances and that is a matter for determination by the jury."

The award of punitive damages against the police sergeant was also upheld by the court. Punitive damages can be awarded only where there is a showing of malice. Malice in this case could be inferred from the fact that the use of "the hole" was limited to prisoners who were unruly. According to testimony, once the unruly inmates had calmed down, they were taken out of "the hole." Since Falkenstein was left in "the hole" after he had calmed down, the Supreme Court concluded that the jury could have validly inferred that the police sergeant acted maliciously.

Owens v. ***Haas***, 601 F.2d 1242 (2d Cir. 1979), ***cert. denied***, 444 U.S. 980 (1979). The county may be held liable for failing to properly train jail staff if that failure amounts to "gross negligence" or "deliberate indifference" to the inevitable consequences of a lack of training. In addition, there need not be a "pattern" of abuse for the county to be liable, but liability under Section 1983 can arise from a single incident if that incident is serious enough to indicate some level of "official acquiescence." (In this case, the incident was the beating of a prisoner who refused to leave his cell, by the defendant and other officers.)

If the plaintiff can show an official "custom or policy" stemming from or resulting in a conspiracy, and if the conspiracy implicates the county itself, then the county may be liable as a "person" under Title 42, Section 1985 (the conspiracy section of the Civil Rights Act).

Moomey v. ***City of Holland***, 490 F.Supp. 188 (W.D. Mich. 1980). A superior officer is not liable for the acts of his inferiors in a civil rights litigation without personal involvement. Failure of the booking officer to remove the inmate's belt with a resulting suicide is nothing more than negligence, and does not state a claim for violation of civil rights.

Roberts v. ***Stokely***, 388 So.2d 1267 (2d Dist. Fla. Ct. of Ap. 1980). Suit filed against the sheriff of Pinellas County for negligently, recklessly or willfully failing to prevent a suicide when he knew or should have known that decedent was likely to commit suicide. The trial court granted summary judgment for plaintiffs and the Court of Appeals upheld this decision. Liability was based on knowledge of a propensity towards suicide. In the record were a physician's instructions to the Sheriff that the decedent was suicidal.

Pantoja v. ***City of Gonzales***, 538, F.Supp. 335 (N.D. Cal. 1982). On the morning of August 21, 1981, police officers employed by defendant City of Gonzales, found Antonio Pantoja lying on the street, apparently drunk and asleep. Not having roused him, they took him into custody as a public drunk unable to care for his own safety. He was placed in a holding cell to sober up. Eight hours later he was found dead. An autopsy report attributed death to a blow to the head, possibly suffered during an assault before he was taken into custody.

Pantoja's heirs brought action under Section 1983 and certain other provisions of law, alleging that defendants' treatment of their decedent denied him due process of law. Specifically, they contended that the police officers denied Pantoja protection and medical care, and that the city and its supervisory personnel failed to train the officers adequately.

The court addressed the question of whether ***Parratt*** v. ***Taylor***, 451 U.S. 527 (1981) required the plaintiff to pursue a state law tort remedy only. Analyzing ***Parratt*** as well as ***Logan*** v. ***Zimmerman Brush Company***, 455 U.S. 422 (1982), the court held that the availability of a state tort remedy was inadequate: "Under the reasoning of ***Parratt***, as illuminated by ***Logan***, this case falls squarely within the category of cases attacking an established state procedure (including also the allegedly inadequate training of police officers), as opposed to those attacking random or unauthorized and hence unpredictable acts. Where the deprivation occurs as a result of the established practice, procedure or custom of the state authority, as alleged here, the result is not unpredictable and the state has a constitutional duty to prevent it. A post-deprivation hearing provided by the state in the course of a wrongful death action, which may satisfy due process in cases of random and unpredictable acts, is not adequate here. The motion to dismiss must therefore be denied." The court further held: "Here the deliberate custom and procedure of police authorities is challenged, and the availability of a wrongful death action will not satisfy the state's obligation not to deprive a person of life without due process."

Soto v. ***City of Sacramento***, 567 F.Supp. 662 (E.D. Cal. 1983). Placed in an isolation cell following a disturbance, the plaintiff subsequently attempted suicide, suffered severe brain damage, and was unable to care for himself or to communicate with others concerning the incident.

Filing suit, the plaintiff attempted to hold the city and county liable for improperly placing him in an isolation cell and placing him in a cell which was periodically used by prisoners to commit suicide.

The federal district court found that the city and county may be liable, and ordered a jury to resolve these issues, and other elements of the suit which involved alleged excessive use of force by the arresting officers.

Kanayurak v. ***North Slope Borough***, 677 p. 29 893 (AK. 1984). Suit concerned suicide of Lillian Kanayurak, a 42-year-old Eskimo woman, who was incarcerated in the North Slope Borough Public Safety Building. Barrow Kanayurak, as personal representative of the estate of the deceased, brought suit against the North Slope Borough alleging that Borough employees were negligent for not preventing Lillian Kanayruak's suicide. The trial court granted final judgment to the Borough, apparently accepting its argument that they were not liable (1) because it had no notice that Kanayurak would attempt suicide, and (2) because Kanayurak's death resulted from her own intentional conduct. However, a state court later ordered the case to proceed to trial, citing a case which held that a jailer must take extra precaution for the safety of a prisoner he knows is intoxicated or insane (***Wilson*** v. ***City of Kotzebue***).

The state court ruled that the duty to protect the prisoner's health and safety encompasses a duty to prevent even self-inflicted harm assuming that such harm is reasonably foreseeable. The police had reason to believe that Kanayurak was severely depressed. They knew that in the previous few months one of her sons had been burned to death, another son has been stabbed to death, she had been divorced, and her mother had died.

Matzker v. ***Herr***, 745 F.2d 1142 (7th Cir. 1984). A prisoner's right to be free from cruel and unusual punishment is violated when the jailer refused to investigate prisoner's cries for help; additionally, right to be free from cruel and unusual punishment is violated if jailers failed to establish adequate patrol procedures; indifference to complaints with substance and known problems violates right to be free from cruel and unusual punishment.

Garcia v. ***Salt Lake County***, 768 F.2d 303 (10th Cir. 1985). Court held that (1) pretrial detainees are entitled to the degree of protection against denial of medical attention which applies to convicted inmates; and (2) finding against county was supported by evidence of gross deficiencies and deliberate indifference in staffing and procedures to monitor persons admitted to jail in an unconscious condition and who are suspected of being intoxicated.

Violation of arrestee's constitutional rights occurred when, pursuant to practice of sheriff's department but contrary to written policy that unconscious arrestees be taken to a hospital, the arrestee, suspected of being intoxicated, was carried to the jail and placed in holding cell and was checked approximately 30 minutes by a search officer whose only medical training consisted of training in first aid, was examined only once by a medic approximately five hours later, with no medical personnel being present when arrestee, who had not regained consciousness, stopped breathing approximately an hour and half later; there was sufficient evidence of gross deficiencies and deliberate indifferences in staffing and procedures to monitor unconscious detainees to warrant finding of a violation.

Anderson v. City of Atlanta, 778 F.2d 678 (11th Cir. 1985). There was sufficient proof to support jury's conclusion that city had utilized custom, policy, pattern and/or practice of inadequately staffing pretrial detention center and that there was affirmative link between policy and death of pre-trial detainee from drug overdose, and therefore evidence was sufficient to support verdict against city and its director of bureau of corrections under Section 1983.

The court found that a "summary of the testimony and proof at trial indicates that there was certainly enough evidence to permit the jury to return a verdict against Director Hudson and the City of Atlanta that was not founded upon ***respondeat superior***. There was sufficient evidence for the jury to find that Director Hudson, whose acts may be fairly said to represent official policy of the City of Atlanta, knew that the Pre-trial Detention Center was inadequately staffed and that it was difficult for the officers to perform their jobs properly. Thus, it was possible for the jury to decide that there was a conscious decision

on the part of Director Hudson and therefore, the City of Atlanta, not to increase the staff at the Detention Center in the face of complaints of inadequate staffing. The result of this decision was that officers were unable to perform their jobs properly. Furthermore, the jury could have found that Director Hudson and the City of Atlanta knew or should have known that the natural consequence of this failure to adequately staff the jail would impair proper medical care and attention necessary to protect the health of pre-trial detainees."

Partridge v. ***Two Unknown Police Officers***, 751 F.2d 1182 (5th Cir. 1986). In February 1980, a Houston police officer arrested Michael Wayne Partridge on suspicion of burglary and theft. While the officer was investigating the scene of the alleged crime, Partridge became agitated and violent, and attempted to kick the doors and windows out of the car. The officer, who was working alone at the time, requested a two-man unit to transport Partridge to the jail. When the back-up unit arrived, Partridge was still kicking at the doors and windows. A sergeant at the scene asked Partridge's father if the boy had any "mental problems." Partridge's father told the officer that the boy had suffered a nervous breakdown.

The two transporting officers handcuffed Partridge and drove him to the jail. On the way to the jail, Partridge intentionally struck his head at least once against the plexiglass divider between the front and back seats. One of the officers was able to calm Partridge, and by the time they arrived at the jail, Partridge seemed composed. Neither of the two officers called anyone's attention to Partridge's aberrant behavior. Partridge was placed in solitary confinement. The jailer was unaware that Partridge's clinical record showed that he had attempted suicide during an earlier confinement. The records were maintained four doors away from the booking desk. The jailer did see Partridge's two medical alert bracelets, and noted on his booking card "heart and mental." Three hours later Michael Partridge hanged himself.

The parents sued the City of Houston, and the Circuit Court of Appeals ordered the case to trial by ruling that such allegations, if proven, may constitute deliberate indifference to the prisoner's serious medical needs. The court, relying on the ***Estelle*** deliberate indifference standard, ruled that "a prisoner's or detainee's right under the Eighth Amendment to be protected from himself is not unlimited. The 'deliberate indifference' standard is met only if there is a strong likelihood, rather than a mere possibility, that injury will occur. First, a plaintiff must prove that deliberate indifference exists. Other courts have held, and we agree for present purposes, that deliberate indifference exists when action is not taken in the face of 'a strong likelihood, rather than a mere possibility' that failure to provide care would result in harm to the prisoner.

"A plaintiff might also show deliberate indifference by revealing a pattern of medical neglect. Although a delay or denial of medical care may be mere negligence, and thus not actionable under Section 1983, repeated examples of such treatment would indicate a deliberate indifference by prison authorities."

Miga v. ***City of Holyoke***, 497 N.E. 2d 1 (Mass. 1986). The plaintiff had been taken into protective custody after being stopped for drunk driving. There was evidence at trial that one of the same officers involved with stopping her had read and signed a report about an incident eleven days earlier, in which the plaintiff's husband had reported to the police that she had suicidal tendencies and had been hospitalized for that reason, and she had told a detective she had a drinking problem.

Nevertheless, evidence was presented that the plaintiff was placed in a cell while unconscious, that no attempt was made to notify her husband or the nearest detoxification center, that she was not checked every half hour, and that the only police response when other prisoners yelled for help because the plaintiff was trying to kill herself was an obscene, racial epithet uttered by one of the defendants. Some of these actions were shown to be in violation of the department's own regulations.

On appeal, the Supreme Judicial Court affirmed the jury's award of $20,000 in compensatory and $50,000 in punitive damages against each of two individual police defendants, as well as a separate judgment of $13, 260 against the city (for negligence.) The court concluded that the jury was entitled to draw reasonable inferences from evidence set out above that the police officers acted with "deliberate indifference to serious medical needs of a person in police custody" and that their conduct could have been found to be "shocking to the conscience," all in violation of her constitutional right not to be deprived of her life and liberty without due process of law.

Strandell v. ***Jackson County***, 648 F.Supp. 126 (S.D. Ill. 1986). This action arises out of the suicide of a pre-trial detainee in the Jackson County Jail. Detainee was arrested for disorderly conduct and transported to the 60-year-old jail. The complaint alleged that detainee was beaten by officers, stripped, and dragged to an isolation cell. Officers ignored the detainee's screams, the beating of his head and body on the cell wall and bars, and his pleas to be seen by a doctor. Officers also failed to adequately monitor the detainee, who hanged himself on the overhead bars of his cell approximately seven hours after his arrest.

The district court, in ordering the case to proceed to trial, ruled that: "Allegations that county and other governmental defendants were aware of need to improve operation of jail, but nevertheless deliberately chose to operate the jail in a manner that endangered health and safety of pretrial detainees, alleged governmental 'policy' sufficiently to withstand motion to dismiss civil rights action under 42 U.S. C. § 1983 arising out of suicide of pre-trial detainee confined at county jail. . . .Allegation that county's policies and customs subjected pre-trial detainee who committed suicide while confined in county jail to

deprivation of his constitutional rights were sufficient to state claim against county under civil rights statute."

GARCIA V. COUNTY OF EL PASO CONSENT JUDGMENT

Perhaps the one piece of litigation that best exemplifies jail suicide prevention is ***Garcia*** v. ***Board of County Commissioners of the County of El Paso*** (U.S.D.C., District of Colorado, Civil Action No. 83-2-222). Vincent Garcia had been arrested for suspicion of drunk driving in Colorado Springs, Colorado, on March 26, 1982. He was transferred to the El Paso County Jail and placed in an isolation cell where he was found hanged approximately seven hours later. It marked the third suicide at the facility in less than a year.

A lawsuit, filed on behalf of the victim's family, culminated in a Consent Judgment on January 14, 1985. In addition to a $10,000 settlement to the victim's estate and payment of attorney fees, the county agreed to:

1) Provide intensive supervision of all recently admitted inmates during the first twenty-four hours of incarceration. Intensive supervision is to be provided in the following manner:

> a) Not less than one deputy will be assigned to supervise not more than three adjacent wards encompassing the wards designated for recently admitted inmates and inmates requiring mental health care on a 24-hour basis.

2) Replace the doors on all of the existing holding cells in the booking area with "Lexan" glass doors, or similar material, thereby removing the currently existing solid steel doors with the view hole.

3) Modify the existing light fixtures, ventilator covers and other protrusions in all holding cells as recommended by an expert in jail architecture to be designated and hired by the El Paso County Sheriff. Said expert shall furnish a written report of the recommended changes to the El Paso County Sheriff which report shall permanently be retained in the files of that office.

4) Create and maintain a special ward for mental health purposes in which anyone who is in need of special observation as identified by a doctor, psychologist, licensed mental health professional or jail personnel shall be confined.

5) Provide intensive and recurring suicide prevention training to all booking, intake and emergency medical technicians employed by the jail to be provided by the National Institute of Corrections (NIC) or by an expert approved by the NIC or by a licensed mental health professional on at least an annual basis. Additionally, all deputies who are assigned to the jail division shall receive recurring supplementary training in suicide prevention, crisis intervention and general mental health problem recognition from an accredited source. All training shall be comparable in length, quality and content with the training then available from or recommended by the NIC. Such training must either be approved by the NIC or the designated instructor must certify in writing to the Sheriff of El Paso County that the training comports in length, content and quality with the training then available from NIC and that the trainer's qualifications are equivalent to those of NIC instructors.

6) Provide intensive screening of all inmates at the time of booking for risk of suicide. This screening will encompass an indepth questionnaire which comports with current mental health and corrections standards, to be filled out at booking for all newly admitted inmates. Any individual who is identified as having special needs, i.e., those who are intoxicated, in a crisis situation, a suicide risk, or exhibiting any aberrant or unusual behavior will be placed under intensive supervision and a licensed mental health professional notified. Intensive supervision of inmates with an identified risk of suicide shall be no less than that described in paragraph 1 and shall be reasonable under the circumstances. No person who has been identified as presenting risk of suicide shall be placed in isolation without continuous visual observation, which term shall be defined as meaning not less than every 15 minutes.

7) Contract for services of an appropriately licensed mental health professional to be on call 24 hours a day to assist jail personnel involved in the booking/screening/classifying roles to identify individuals with special need for intensive supervision and for any other mental health need.

8) Close Cell 212, an isolation cell on the second floor of the El Paso County Jail, in a manner which will prevent any use of that cell for confinement of inmates. Close Cell 312, an isolation cell on the third floor of the El Paso County Jail, in a manner which will prevent any use of that cell for confinement of inmates.

9) At the time of this agreement, it is contemplated that a new jail will be constructed in El Paso County. Said new jail shall be constructed pursuant to the American Correctional Association's (ACA) standards. The facility, once constructed, will make reasonable good-faith efforts to seek ACA accreditation. The provisions of paragraphs 1 through 8, inclusive, shall apply to any county jail facility in El Paso County which acts as the receiving facility for newly admitted inmates.

10) Defendants agree that a copy of this Consent Decree will be furnished to all employees of the El Paso County Jail.

TASK FORCE ACTIVITIES

The National Center on Institutions and Alternatives is the coordinator of the Jail Suicide Prevention Information Task Force, a one-year project funded by the National Institute of Corrections, U.S. Department of Justice. In cooperation with Juvenile and Criminal Justice International, Inc., and with assistance from the National Sheriffs' Association, the project is currently gathering information from each county and city jail, and police department lockup, on the incidence of jail suicides in 1985 and 1986; conducting 10 regional jail suicide prevention seminars throughout the country; acting as a clearinghouse by providing technical assistance materials; and developing a model training manual on suicide detection and prevention.

During Phase I of the National Study of Jail Suicides, project staff identified approximately 1,000 suicides in our nation's jails during 1985 and 1986. Phase II of the study will collect and analyze demographic data on the 1986 suicides. A final report will be released in September, 1987.

The regional training seminars have commenced. Thus far, eight states/regions have been identified: Arizona/New Mexico, Kansas, Kentucky, Maryland, Minnesota/North Dakota, Ohio, Washington/Oregon/Idaho, and West Virginia. Additional sites are being identified.

Does your jail policy state that an officer is prohibited from entering a cellblock or cell alone? Many facilities have such a policy. What about a common problem in small jails throughout the country — one dispatcher/jailer on duty — who is responsible for monitoring the cellblock while performing his other administrative duties? An inmate who is hanging can be unconscious within seconds, and dead within minutes. What does a dispatcher do upon finding such a victim? Do you call for backup, and wait? Do you cut the victim down? Both? What does your jail policy state? Courts, in ruling on allegations of negligence and/or deliberate indifference, rely heavily upon a facility's rules and procedures.

Project staff are in the preliminary stages of developing a model training manual on suicide detection and prevention. These and other issues will be addressed in the manual. For example, does your jail policy call for "preserving the crime scene" and the taking of photographs before the body is taken down? Are the sheriff or police chief called before the inmate is cut down? Is your facility equipped with an instrument capable of cutting through a thick noose, such as a seatbelt cutter often used by rescue squads?

Project staff would like to hear from those facilities concerned about these and other issues pertinent to jail rules and procedures in suicide prevention.

For more information on the Project, contact either of the co-directors:

Lindsay M. Hayes
National Center on Institutions and Alternatives
814 North Saint Asaph Street
Alexandria, Virginia 22314
(703) 684-0373

RE: Research, Clearinghouse

Joseph R. Rowan
Juvenile and Criminal Justice International, Inc.
381 Owasso Boulevard
Roseville, Minnesota 55113
(612) 481-9644

RE: Seminars, Training Manual

This technical update, published quarterly, is part of the continuing effort of the Jail Suicide Prevention Information Task Force to keep state officials, individual correctional staff, and interested others aware of developments in the field of jail suicide prevention. Please contact us if you are not on our mailing list, or desire additional copies of this publication. As the Project acts as a clearinghouse in jail suicide prevention information, readers are encouraged to forward pertinent materials for inclusion into future updates.

This project is supported by grant number GO-3 from the National Institute of Corrections, U.S. Department of Justice. Points of views or opinions stated in this document are those of the author(s) and do not necessarily represent the official position of policies of the U.S. Department of Justice.

THE NATIONAL CENTER ON INSTITUTIONS
AND ALTERNATIVES

814 NORTH SAINT ASAPH STREET
ALEXANDRIA, VIRGINIA 22314
(703) 684-0373

NON-PROFIT
ORGANIZATION
U.S. POSTAGE
PAID
PERMIT NO. 739
ALEXANDRIA, VA

JAIL SUICIDE UPDATE