JAIL SUICIDE UPDATE

Spring 1994 Volume 5 • Number 4

U.S. Justice Department's Investigation of Jail Suicides in Mississippi: A Status Report

On March 1, 1994, officials in Jones County, Mississippi entered into a consent decree with the U.S. Justice Department that will require them to dramatically upgrade conditions of confinement in its jail. The facility, located in Laurel, was one of 18 city and county jails in Mississippi investigated by the Justice Department during the past year for grossly substandard living conditions and inadequate jail suicide prevention procedures. In regard to the Jones County Jail, the Justice Department criticized the 94-year old facility for its pervasive filth, serious state of long-standing neglect, and significant deterioration. Initiated in May 1993, the investigation consisted of on-site inspections, reviews of the jail's records, and interviews with staff and inmates. The investigation revealed "unsafe and unsanitary conditions so severe throughout the facility that the jail is unfit for human habitation."

In September 1993, the Justice Department intervened in a private lawsuit filed by inmates alleging unconstitutional conditions of confinement. Under terms of the March 1994 consent decree [Crosby v. *Jones County, et. al.*, C. A No. H92-0235 (P)(N)] filed in the United States District Court for the Southern District of Mississippi, Jones County must construct a new jail by March 1995, provide correctional officer training, develop fire safety procedures, ensure adequate medical care, create safe and sanitary conditions, and provide appropriate security and supervision of inmates. In addition, the county must develop and implement a suicide prevention program in the jail. In announcing the settlement, James P. Turner, Acting Assistant Attorney General for the Justice Department's Civil Rights Division, stated that, "When conditions are as deplorable as our investigation revealed, we must act to correct them. I applaud the cooperative efforts of both federal and local officials in reaching this agreement."

The Jones County Jail is not the only facility to be criticized recently by the Justice Department for unconstitutional conditions of confinement. By way of background, Mississippi does not have any state jail standards nor inspection programs, and offers little, if any, technical support to local jailers. Mental health providers are reluctant and often refuse to provide services to jail inmates. Not surprisingly, many of the 85 county jails in Mississippi are in deplorable condition, with underpaid and untrained staff, and few, if any, written policies and procedures. And, were it not for an investigative series by the state's largest newspaper *(The Clarion-Ledger)* last year, the total number of jail suicides in Mississippi would still be unknown. The newspaper's investigation revealed that 41 county and city jail suicides occurred in Mississippi from 1987 through 1992 — almost 50 percent of which involved black victims. Given the state's infamous civil rights history, the *Clarion-Ledger* investigation rekindled suspicions that deaths of the black inmates — all by hanging — were lynchings disguised as suicides. In March 1993, civil rights leaders held two days of highly-publicized hearings in the state capitol of Jackson. Although no evidence was presented that the deaths were anything other than suicides, civil rights leaders persuaded the federal government to conduct a formal investigation.

In announcing that the Justice Department would conduct a thorough inquiry of all the jail suicides, U.S. Attorney General Janet Reno declared on April 13, 1993 that "those numbers of deaths are unacceptable" and that investigators will "get to the bottom of" the question — "How could that many people die?" The Special Litigation Section of the Department's Civil Rights Division was subsequently assigned to the Mississippi investigation, and was able to intervene under the legal aegis of the "Civil Rights of Institutionalized Persons Act" (CRIPA). According to CRIPA:

> Whenever the Attorney General has reasonable cause to believe that any State or political subdivision of a State, official, employee, or agent thereof, or other person acting on behalf of a State or political subdivision of a State is subjecting persons residing in or confined to an institution...to egregious or flagrant conditions which deprive such persons of any rights, privileges, or immunities

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secured or protected by the Constitution or laws of the United States causing such persons to suffer grievous harm, and that such deprivation is pursuant to a pattern or practice of resistance to the full enjoyment of such rights, privileges, or immunities, the Attorney General, for or in the name of the United States, may institute a civil action in any appropriate United States district court against such party for such equitable relief as may be appropriate to insure the minimum corrective measures...(96th Congress, 1980).

Launched in May 1993, the Justice Department's investigation would become unprecedented. Although the agency had previously investigated numerous alleged "egregious conditions" at individual facilities throughout the country, it was rare to converge upon numerous jails within one state, as well as unusual to focus on suicide prevention procedures. And while the Justice Department's interest was sparked by the publicity surrounding jail suicides in Mississippi, the investigation focused on general conditions of confinement (and suicide prevention procedures) at 18 local jurisdictions alleged to have the worst jail facilities. In addition to Jones County, investigations were conducted within the following county jails: Alcorn, Forrest, Grenada, Harrison, Lauderdale, Lee, Neshoba, Scott, Simpson, and Sunflower. Investigations were also conducted within the following city jails: Corinth, Forest, Grenada, Jackson, and Tupelo. Finally, two juvenile detention facilities, located in both Harrison and Hinds counties, were also examined. The investigative team comprised several Justice Department personnel, as well as national experts in the area of correctional management, medical care, environmental safety, and jail suicide prevention.

The investigation, which included on-site inspections of each facility, thorough critique of jail procedures, review of suicide incident reports, and interviews with both staff and inmates, was conducted in May through July 1993. Pursuant to CRIPA, "fact-finding" reports that detailed unconstitutional practices were subsequently forwarded to each of the 18 jails late last year. All of the 18 jails were cited for various grossly inadequate conditions ranging from maggot-infested cells to racially segregated drunk tanks and life-threatening fire hazards. Other deficiencies included insufficient staffing and poor training, infrequent inmate supervision, inadequate or non-existent medical and mental health services, and general lack of written policies and procedures. Many of the jails were also criticized for their "pervasive filth, serious state of long-standing neglect, and significant deterioration." In fact, in addition to Jones County, the Justice Department called for the closing of several other jails because they were found to be "unfit for human habitation."

In regard to suicide prevention, the findings in Jones County were indicative of conditions in all 18 Mississippi jails:

> There is no suicide prevention program at the jail and mental health services are not available. As well, there is no detoxification program. There has been one suicide and three suicide attempts at the jail during the past two years. Inmates with mental disturbances or who are at risk to commit suicide are placed in one of three two-bed steel cages in isolation in an area called sick bay. The three 'sanity' cells each measure five feet by six feet with approximately half that space occupied by bunks, a toilet and a sink. Inmates and non-criminal mentally ill persons being held pursuant to Mississippi's commitment law, and awaiting admittance to a state psychiatric facility, can and have been incarcerated in 'sanity' cells for months. Our consultant found that such cage cells, with exposed, reachable overhead bars are 'absolutely suitable' for committing suicide.

Although CRIPA provides clear authority for the Attorney General to initiate legal action in order to correct unconstitutional conditions, the Act also allows the Justice Department to avoid the need for litigation by encouraging "the appropriate officials to correct the alleged conditions and pattern or practice of resistance through informal methods of conference, conciliation and persuasion..." Therefore, in accordance with CRIPA, each of the Justice Department's "fact-finding" reports not only listed the egregious conditions, but also detailed the remedial measures necessary to voluntarily correct problems within the 18 jail facilities. For example, all of the jails were required to develop and implement a comprehensive suicide prevention program, and the following summarization was recommended in each of the facilities:

1. The Defendants shall not house a suicidal and/or mentally ill person in excess of forty-eight (48) hours, except for good cause shown;

2. The Defendants shall ensure that suicide prevention measures are in place. To this end, the Defendants shall:

   (a) repair and retrofit all light fixtures in the cells and living areas, clear all blocked areas of air supply and exhaust vent;

   (b) purchase rescue equipment including, but not limited to, a first aid kit, a 911 rescue tool, disposable gloves, and a CPR pocket mask;

   (c) screen all inmates for suicide risk and other special needs prior to their admission into the jail. Such screening shall thoroughly assess a potential inmate's mental health and shall comport with current mental health professional and correctional standards;

   (d) provide eight (8) hours of training by a suicide prevention expert or a licensed mental health professional to all personnel/ officers who monitor or supervise inmates. Such training shall include, but not be limited

to, the proper response to a suicide or suicide attempt, including how to cut down a hanging victim and other first aid-measures, the identification and screening of special needs inmates and training about the high-risk groups and periods of suicides and suicide attempts; and

(e) ensure that mace is never utilized on suicidal inmates.

3. The Defendants shall develop and implement written policies and procedures on suicide prevention and the treatment of special needs inmates, which shall include, but not be limited to, the following:

(a) the appropriate housing of special needs inmates;

(b) the establishment of two levels of supervision for suicidal and/or special needs inmates — *Constant Watch* and *Close Watch*. *Constant Watch* is reserved for the inmate who is actively suicidal, either by threatening or engaging in the act of suicide. The inmate shall be observed on a continuous, uninterrupted basis (i.e., one-on-one) by an officer who has a clear and unobstructed view of the inmate at all times. *Close Watch* is reserved for the inmate who has expressed thoughts of suicide and/or has a prior history of suicidal behavior, but is *not* considered actively suicidal. The inmate shall be observed by an officer at staggered (e.g., 5, 15, 10, 7, etc.) intervals not to exceed every 15 minutes.

The officer shall document the *Constant Watch* check every 15 minutes in a suicide watch log, and document the *Close Watch* check as the staggered check occurs. Closed circuit television and/or inmate trustees may supplement, but never be utilized to substitute, the physical observation of the officer.

(c) the communication of information relating to special needs inmates between and among jail staff members, between arresting and transporting officers and jail staff, between jail staff and the administration, and between jail staff and the special needs inmate;

(d) the notification by jail staff to local or state mental health authorities that a special needs inmate (except intoxicated) has been admitted to the jail;

(e) the assessment of all special needs inmates as soon as reasonably possible by a qualified mental health professional to assess the inmate's level of suicide risk;

(f) the establishment of a mechanism by which jail staff will communicate with health care providers regarding the status of potentially suicidal inmates or inmates who have recently attempted suicide;

(g) the establishment of a mechanism by which jail staff will refer potentially suicidal inmates and inmates who have recently attempted suicide to mental health care providers or facilities for placement;

(h) the documentation of all attempted and completed suicides and notification to jail officials, outside authorities and family members of all attempted and completed suicides; and

(i) the establishment of follow-up and administrative review procedures for all attempted and completed suicides, including the determination of what changes, if any, are needed in the Suicide Prevention Program.

To date, all of the 18 Mississippi jails have been persuaded to correct the unconstitutional conditions cited in the Justice Department's "fact-finding" reports. In fact, in addition to Jones County, several jurisdictions have already agreed to build new jails. The Justice Department hopes to have signed consent decrees with the remaining 17 jurisdictions within the next few months, and has agreed to provide training and other forms of technical support to those jurisdictions requesting assistance in remedying the poor conditions. The Justice Department will also monitor compliance to the corrective action for an unspecified time period.

Although many jail officials in Mississippi welcomed (even invited) the Justice Department investigation, there were also those who criticized the federal intervention and resulting publicity. "It's pretty apparent that Mississippi has been singled out," said one sheriff. "I can see the need for something to be done to solve the problems, but I really believe Mississippi caught a black eye on this that it didn't deserve."

FINAL NOTICE TO OUR READERS

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