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**Assessing Liability Exposure
in Jail Inmate Suicide Cases:
Three Questions to Ask
by Richard G. Kiekbusch, Ph.D.**

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I. INTRODUCTION

Suicide is the leading cause of death among America's jail inmates, accounting for more than 30 percent of deaths in custody in the Nation's jail facilities (Tan de Bibiana, et.al., I). The Justice Department's Bureau of Justice Statistics, in its most recent reporting on jail inmate suicides, confirmed that 372 jail inmates committed suicide in 2014—slightly more than one per day (Tartaro, 44). These jail inmate suicides frequently result in lawsuits filed by surviving family members and others.

1. THREE QUESTIONS

How, then, might defendants' and plaintiffs' counsel involved in such litigation best assess the liability exposure of the jail in which the inmate suicide took place? I suggest that three questions be asked:

1. WAS THE INMATE THOROUGHLY SCREENED AT INTAKE WITH RESPECT TO KNOWN SUICIDE RISK FACTORS?

While it is necessary to ask an incoming inmate if he is thinking about taking his life and to ascertain if he has attempted to do so previously, these two inquiries do not constitute a sufficient suicide screening regimen. More information must be acquired through the questions and observations of alert booking officers. Known suicide risk factors include the following:

- *The inmate is thinking about killing himself.* Absolutely must be asked at booking. The single most important indicator of suicide risk is the incoming inmate's statement that he is thinking about killing himself.
- *The arresting/transporting officer thinks the inmate may be suicidal.* This is the second most important indicator of suicide risk-i.e., the arresting/transporting law enforcement officer, by virtue of the inmate's words or behavior in transit to the jail, is led to believe that the inmate is contemplating a suicide attempt. Because many law enforcement officers do not think to report such speech or behavior to booking officers, jail policy should require booking officers to inquire about it. If the arresting/transporting officer does report such speech or behavior, he should be asked to elaborate.
- *The inmate has attempted suicide on one or more prior occasions.* The booking officer(s) should both ask the inmate if he has previously attempted suicide and check available records.
- *The inmate is under the influence of drugs or alcohol.* The booking officer(s) should be alert for signs of intoxication and should check the results of any tests that may have been conducted (e.g., field sobriety test, breathalyzer).
- *The inmate has a history of drug or alcohol abuse.* Does the inmate drink or use drugs? He should be asked this at booking. The booking officer(s) should also check available records to see if the inmate is a known abuser and frequent inmate

(at the present jail or elsewhere) and/or detox patient.

- *The inmate has a history of psychiatric problems.* Is the inmate under psychiatric treatment now or has he been treated previously? Is he on psychotropic medication now, or has he been previously? The booking officer(s) should ask him these questions and check available records. The inmate's property should also be checked for psychotropic medications.
- *The inmate shows signs of depression.* Some mental health and correctional professionals consider this to be the #1 suicide risk factor. Is the inmate, through his speech, behavior, or overall affect exhibiting signs of hopelessness, helplessness, or dejection? Professionally diagnosed clinical depression is not the focus here. Rather, the focus is on what I would call situational despondency, perhaps induced by being arrested and brought to the jail. It may be enough to trigger momentary suicidal ideation and a subsequent suicide attempt.
- *The inmate appears to be unusually embarrassed or ashamed.* Such feelings are common among those being booked into jail for the first time or those being charged with a crime that is the object of widespread public disgust (e.g., pedophilia). Such inmates may be extremely concerned about the reactions of significant others (e.g., parents, spouse, children, employer).
- *The inmate appears to be extremely anxious or frightened.*
- *The inmate displays emotional instability.* Does the inmate exhibit mood swings (e.g., intermittent crying and laughing) or emotional extremes (e.g., uncontrollable crying or laughing)?
- *The inmate displays bizarre behavior.* Is the inmate incoherent or unresponsive to the questions being asked by the booking officer(s)? Does he claim to see or hear things that are not there, or seem out of touch with what is happening at the moment?
- *The inmate is unusually angry or agitated, or assaultive.*
- *The inmate has had a recent traumatic experience.* Has the inmate recently experienced the death of a loved one, the loss of employment, a divorce, a frightening medical diagnosis, etc. The experience in question may have precipitated the inmate's present arrest (e.g., domestic violence).

To the extent that the decedent inmate had not been purposefully assessed at intake with respect to some semblance of the above items, and possibly some others suggested by the jail's mental health services provider, I contend that he had not been thoroughly screened with respect to known suicide risk factors.

2. WAS THE INMATE REFERRED TO MENTAL HEALTH PROFESSIONALS?

The objective of the screening process discussed above is to identify incoming inmates who are *possibly* suicidal. The jail's administration, preferably in conjunction with the jail's mental health services provider, should have provided policy guidance to its officers as to which single risk factors or combination of factors characterize an inmate who is *possibly* suicidal. A definitive determination as to whether or not an inmate is, in fact, suicidal can be made only by a properly trained and credentialed mental health specialist. At no time should a detention officer, or even a physician or other member of the jail's medical team, be expected or allowed to make such a determination. For this reason, it is imperative that an incoming inmate identified by jail staff as *possibly* suicidal be promptly referred to the jail's mental health service provider for definitive suicide risk evaluation, as well as recommendations regarding housing location, intensity of supervision, and possibly continued mental health involvement.

To the extent that the decedent inmate had not been seen by a mental health specialist, I contend that he had not been properly assessed for suicide risk level, housing and supervisory requirements, and the need for continued mental health services.

3. WAS THE INMATE PLACED ON SUICIDE WATCH?

The data show that the hours and days during and immediately following admission are the time period during which suicide attempts by jail inmates are most likely to occur (Kiebusch, 12-2). For this reason-assuming an inmate has been screened for suicide risk factors at intake, identified as possibly suicidal, and referred to mental health-it is essential that he be placed on suicide watch pending the involvement of a mental health specialist. An effective suicide watch protocol features at least these three elements:

- *The room or cell in which the inmate is housed contains no implements which could be used by the inmate to take his life.* There certainly should be no sharp objects present, either affixed to the cell or carried in by the inmate. Also, given

that hanging is the most frequently employed method by which jail inmates commit suicide (Kieckbusch, 12-1), the cell should contain no implements that could be used by the inmate to hang himself (e.g., bed sheets, clothes hangers, beds with railings or frames, telephone cords, protruding plumbing fixtures), and the inmate should not be allowed to take any such implements into the cell with him (e.g., shoe laces, belts, his own clothing). Placing the inmate in a suicide gown may be necessary. If no such suitable cell is available, seating the inmate in a chair in the booking area, possibly restrained, may be the only viable option. The proverbial bottom line is that jail staff must do whatever is necessary to keep the inmate alive.

- *The inmate is continuously observable.* The inmate need not be constantly observed but, rather, must be constantly *observable*. In most instances, the inmate will be placed in a cell. It is critical that the cell have no blind spots, that its door have a vision panel (the larger the better) that remains open and unshuttered at all times, and that its interior be observable by jail staff with as little effort as possible. If this level of supervision and surveillance requires an officer to be brought in an overtime, then an officer should be brought in. If the jail's physical design precludes this level of supervision and surveillance short of placing the inmate in a chair in the booking area, restrained if necessary, then that should be done. Should it come up, the duty of jail staff to do whatever is necessary to keep the inmate alive trumps any inmate privacy concerns.

- *The inmate is observed by jail staff at least every 15 minutes.* Direct observations should be conducted more frequently if the inmate has presented a substantial number of suicide risk factors, if he has presented additional risk factors since booking, or *if* his presentation of risk factors has increased in frequency or intensity. There should be no question as to which special staff members are to do the observing, and each observation should be logged. A senior supervising member of the custody staff (e.g., Sgt., Lt., Capt.) should regularly check the log to ensure that these critical observations are, in fact, taking place at the prescribed intervals.

I emphasize custody staff, as opposed to medical staff, because the management of all inmates, including those who are suicidal, is a custody responsibility, not a medical one. Even if medical staff are assisting in some capacity, including making suicide watch observations, custody supervisors are still responsible for oversight and accountability. Cameras may certainly be useful supplements to direct staff observation, but they should never be used in place of such observation.

In the execution of suicide watch, as with any other facet of inmate supervision, there is absolutely no substitute for direct, face-to-face supervision by competent, well trained, and properly supervised jail officers. And once again, if limited on-duty staff or an outdated physical plant precludes this level of observation, then the use of overtime staff or seating the inmate in the booking area may be necessary. Jail staff must do whatever is necessary to keep the inmate alive.

To the extent that the decedent inmate, following his intake assessment as possibly suicidal, had not been placed on a purposeful suicide watch regimen similar to the one described above, I contend that he had not been responsibly supervised by jail staff.

III. GENERAL POPULATION INMATES

Some inmates don't become suicidal until they have been in the jail's general population for an extended period of time --often weeks and months. It is difficult for jail staff to become aware of possibly suicidal general population inmates during the course of their routine supervision of those inmates. Nevertheless, if it is documented that jail staff were aware of, and chose to ignore, one or more known suicide risk factors, liability might attach. Known general population risk factors include the following:

- An inmate starts talking about killing himself.
- An inmate begins showing signs of depression.
- An inmate becomes very anxious or frightened.
- An inmate becomes emotionally unstable.
- An inmate starts behaving bizarrely.
- An inmate becomes unusually angry or agitated.
- An inmate undergoes a highly traumatic experience (e.g., assaulted by another inmate, given a long prison sentence, served with divorce papers).
- An inmate begins mutilating himself.

- An inmate begins giving away his personal property to other inmates.
- In a dormitory, an inmate asks to be moved to a bunk that is more obscure and more difficult to observe than his current location.

Just as at intake, general population inmates deemed to be possibly suicidal by jail staff should be promptly referred to mental health and placed on suicide watch.

IV. CONCLUSION

By the way of conclusion, I offer the following points:

- Like any suicide, a jail inmate suicide is a tragedy.
- It is a tragedy, however, that can often be prevented.
- The most effective means of jail inmate suicide prevention is a three-pronged jail staff regimen consisting of: **SCREENING** at intake with respect to known suicide risk factors, prompt **REFERRAL** to mental health, and placement on **SUICIDE WATCH**.
- Jail inmate suicides are often followed by lawsuits filed by surviving family members and others.
- The extent of the jail's liability exposure in such cases can, to a great extent, be assessed by inquiring as to whether the jail's staff executed the aforementioned three-pronged suicide prevention regimen (i.e., the **THREE QUESTIONS** discussed in section II).
- While this article is focused on the assessment of a jail's liability exposure in the wake of an inmate suicide, it is far preferable for a jail staff to implement the three-pronged regimen (**SCREENING-MENTAL HEALTH REFERRAL-SUICIDE WATCH**) and prevent the suicide in the first place.

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Related Monthly Law Journal article: [Civil Liability for Prisoner Suicide](#), 2007 (2) AELE Mo. L.J. 301.

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