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Civil Liability for Prisoner Suicide

Suicides by persons in custody, whether pre-trial detainees or convicted prisoners, and whether attempted or successful, is a troublesome and recurrent issue for jails and prisons. While it was once assumed by some that this was largely a question of suicide by pre-trial detainees in jail, recent studies have shown that, while the suicide rate is, indeed, much higher in jails than in prisons (approximately triple), the suicide rate in prisons is nevertheless much higher than in the general population.

There are also few other areas in which it is as predictable that a facility will face a lawsuit following an incident—as most suicide deaths of persons in custody appear to be followed by either a federal civil rights lawsuit or a state law wrongful death lawsuit by the decedent's estate or surviving family.

In the following article, we briefly examine some of the recent case law that has developed in this area, both in federal and state courts, and highlight some helpful resources.

Contents

1. Federal civil rights legal standard for liability.

Ordinarily, government has no duty to protect any specific individual from harm, including self-inflicted harm, such as suicide. Courts have, however, found that there are increased obligations to prisoners and detainees, largely premised on the fact that their freedom has been taken away, and they are therefore not able to obtain assistance for themselves, including necessary medical care (of which psychological, psychiatric and mental health care are a part). Nor are their friends and family in a position to do so, given their incarceration.

The prisoner or detainee and the place that they are confined is under the "exclusive control" of the criminal justice agency and its staff, who are responsible for the care and custody of the prisoner or detainee.

Accordingly, courts, including federal courts, have found that some duty does exist for correctional facilities to protect prisoners from suicide, just as it must furnish necessary medical care, and some level of protection against assaults by other prisoners or the use of unnecessary force by staff members.

In one prisoner protection case, Farmer v. Brennen, No. 92-724, 114 S.Ct. 1970 (1994) (involving protection of a prisoner from alleged beating and rape by another prisoner), the U.S. Supreme Court explained:

> "[W]hen the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic needs - e.g. food, clothing, shelter, medical care, and reasonable safety - it transgresses the substantive limits...[of the Constitution]."

The duty to protect convicted persons in custody from self-inflicted harm is analyzed under the 8th Amendment's prohibition of cruel and unusual punishment. In Bell v. Wolfish, No. 77-1829, 441 U.S. 520 (1979), the U.S. Supreme Court ruled that pre-trial detainees who have not been convicted are entitled to at least that same level of protection. In Estelle v. Gamble, No. 75-929, 429 U.S. 97 (1976), the Supreme Court held that deliberate indifference to a prisoner's serious medical needs violates the 8th Amendment because it constitutes an "unnecessary and wanton infliction of pain."

There has not been a U.S. Supreme Court case directly involving the right to protection against suicide, but the legal standard set forth in Estelle, "deliberate indifference" to a known substantial risk of harm has been applied to prisoner suicide cases by the federal courts. Such "deliberate indifference" is much more than mere negligence, and does not require that every conceivable thing possible be done to prevent each suicide. Some suicides, obviously, are going to occur, no matter what anyone does to attempt to prevent them.

Under the "deliberate indifference" standard, a correctional employee who makes good faith efforts to respond appropriately to indications that the prisoner may be a suicide risk will ordinarily not be found liable if, despite those efforts, the prisoner subsequently succeeds in killing himself. This is illustrated by a recent case in which a correctional officer to whom a prisoner indicated suicidal feelings was found to not have acted with deliberate indifference when he immediately passed on the prisoner's request to see a counselor and returned to the cell several times to see if he was ok. Fifty-five minutes after the prisoner made his statement to the officer, he hung himself to death in his cell. The counselor had been unable to come immediately to see the prisoner, and the prisoner allegedly then told the officer that he could wait. This officer, far from acting recklessly or intentionally disregarding a known risk of suicide, also returned to the prisoner's cell a number of times to make certain that nothing was wrong, and then passed on responsibility for monitoring the prisoner to another officer, who did make a subsequent cell check. Nothing in the record supported an inference that the officer to

whom the prisoner had expressed his suicidal feelings intentionally disregarded a known, imminent suicide risk. (The court also ruled that other officers, who knew of the request to see a counselor, but did not know the reason for the request, could not be found to have acted with deliberate indifference to a suicide threat they did not know about.). Collins v. Seeman, No. 05-1309, 2006 U.S. App. Lexis 23092 (7th Cir.).

Similarly, deputies who placed an intoxicated detainee who had made suicidal threats in a cell under video surveillance were not liable for his subsequent successful suicide despite failure to remove the shoelaces he used to hang himself. Short v. Smoot, No. 05-1284, 2006 U.S. App. Lexis 2564 (4th Cir.). The appeals court found that the first-shift officers' response to the prisoner's risk of suicide was "objectively reasonable" and sufficient to prevent liability under the Eighth Amendment. They placed the detainee in a cell under video surveillance, and this was sufficient to avoid a claim for deliberate indifference, even if additional precautions "might also have been advisable."

The appeals court did uphold, however, the rejection of summary judgment for a deputy on the evening shift, based on evidence which supported a reasonable inference that he observed the detainee, on the video monitor, removing the laces from his shoes and, over a period of twenty to thirty minutes, climbing on the bars of his cell, tying his shoelaces to the bar, placing a noose around his neck, and testing the weight of the rope. If true, the deputy's failure to make any effort to stop the ongoing suicide attempt would constitute deliberate indifference.

Clearly, once correctional personnel know that a suicide attempt is actually taking place, they must take prompt and appropriate action. In Bradich v. City of Chicago, No. 04-3626, 2005 U.S. App. Lexis 13131(7th Cir.), for instance, the court ruled that if officers waited ten minutes to summon medical assistance after discovering that arrestee had hung himself in his cell, this could be found to be deliberate indifference, serving as a basis for liability for his death.

The mere fact, standing alone, that a detainee made a prior suicide attempt does not necessarily result in liability when a detainee subsequently successfully commits suicide, as shown by one recent case. Perez v. Oakland County, No. 05-1583, 2006 U.S. App. Lexis 25754 (6th Cir.). In that case, an 18-year-old detainee at the Oakland County Jail in Pontiac, Michigan hung himself from a bedsheet tied to a vent in his single cell in the facility, resulting in his death three days later. His estate subsequently pursued a federal civil rights lawsuit against the county, the caseworker/counselor at the jail, the county sheriff and several of his deputies, and a jail psychiatrist claiming that they violated his Eighth Amendment rights by failing to provide appropriate mental health treatment and suicide monitoring.

The appeals court noted that the detainee attempted suicide in his cell only a month or so before his successful attempt. It found that, despite this evidence, and other evidence of suicidal thoughts in the past, there were reasons to doubt the conclusion that he posed a strong likelihood of another suicide attempt, including the opinion of a licensed and trained psychiatrist during an evaluation shortly before the final attempt, and the

counselor's notes from her counseling sessions with the detainee, during which he denied any suicidal intention.

Despite this, the appeals court ruled, there was a question of fact as to whether there was a recognizable significant likelihood of the detainee attempting suicide, as well as on whether the caseworker/counselor knowingly disregarded this risk by moving the detainee to single cell housing without first requesting a medical judgment from the psychiatrist as to whether that placement was appropriate. Even if there was an arguable claim that the caseworker/counselor acted with deliberate indifference, the court found, she was still entitled to qualified immunity under the circumstances, because of the absence of a clearly established right that was violated by her actions at the time, in the fall of 2002.

While she may have demonstrated "poor judgment" in making critical decisions based on her own assessment of the detainee's risk of suicide, and may have underestimated his risk of suicide, making a cell-assignment decision without first consulting the detainee's treating physician or prison psychiatrist, these alleged errors were at most negligent, but the court found no case law to show that any such errors would clearly violate the detainee's Eighth Amendment rights.

The appeals court also rejected the argument that the county acted with deliberate indifference by allowing case workers to make housing decisions, given the lack of any evidence that the practice had ever previously resulted in a suicide or attempted suicide by another inmate, either at the county jail or in another jail across the country.

Correctional employees may, in some instances, escape liability by showing that they were reasonably relying on the opinions and directions of trained medical personnel. In Drake v. Koss, No. 05-1464, 2006 U.S. App. Lexis 5396 (8th Cir.), for instance, jailers were found not to have acted with deliberate indifference in failing to prevent a detainee's suicide attempt when they based their actions on the opinion of a psychiatric doctor that the prisoner, in previously stabbing himself in the wrist and drinking cleaning solution, was not suicidal, but was instead merely "acting out" and "malingering."

"Deliberate indifference" is a standard that only finds defendants liable for failing to take arguably necessary action in response to a **known** serious risk of self-harm. In Grayson v. Ross, No. 04-3577, 2006 U.S. App. Lexis 18061 (8th Cir.), a sheriff and the arresting officer were found not liable for the death of a detainee who died from self-mutilation in a county jail after an arrest for intoxicated driving. The jailers were also not found liable for deciding to admit the detainee to the jail rather than sending him to a hospital, because he appeared calm, and they did not know the amount of drugs he had ingested, or that he had a need for immediate medical treatment. The court denied the jailers qualified immunity, however, on a claim that they failed to adequately monitor him following his intake, when they could observe his condition. Once incarcerated in the jail, the detainee engaged in conduct as screaming and removing his clothes.

Similarly, in Gray v. City of Detroit, No. 03-2515, 2005 U.S. App. Lexis 3419 (6th

Cir. 2005), the court ruled that the city and a police officer were not liable for the suicide of a pre-trial detainee in his cell since the officer did not know that the detainee was suicidal. It further found that the city had constitutionally adequate suicide prevention policies, so that there was no basis for municipal liability.

In Gray, the court commented that:

> Pre-trial detainees do not have a constitutional right for cities to ensure, through supervision and discipline, that every possible measure be taken to prevent their suicidal efforts. Detainees have a right that city policies, training and discipline do not result in deliberate indifference to foreseeable and preventable suicide attempts. Here, the plaintiff never made any statements that could reasonably be interpreted as threatening to harm himself, and none of his destructive acts were self-directed. There was no indication that he would turn his anger and agitation upon himself. The city's agents complied with city policies regarding medical care.

See also, Woloszyn v. Lawrence, No. 03-2390, 2005 U.S. App. Lexis 1417 (3d Cir.), (county, warden, and jail personnel had no liability for pre-trial detainee's suicide when there was nothing which would have put them on notice that he was particularly susceptible to suicide attempts). In that case, the detainee showed no signs of depression, and allegedly explicitly stated that he was not suicidal. He was also "polite, cooperative, alert and not agitated" during a medical assessment performed by a nurse, and had no psychiatric history. The nurse still recommended that he be observed hourly for signs of alcohol withdrawal, and he was placed in a unit where the prisoners were actually checked every 30 minutes. 32 minutes after one such check, he was found hanging in his cell. Under the circumstances, the court found no evidence that the defendants had knowledge of any "particular vulnerability" to suicide. The court rejected the argument that a correctional officer acted improperly in failing to do five-minute suicide checks of the prisoner, when he was not ordered to do so.

Some other federal cases of interest include:

*Gaston v. Ploeger, No. 04-2368, 399 F. Supp. 2d 1211 (D. Kan. 2005), holding that a county sheriff was not entitled to summary judgment on claims that he was individually liable for a jail detainee's suicide on the basis of failure to train personnel on the risk of detainee suicide.

* Snow v. City of Citronelle, No. 04-14409, 2005 U.S. App. Lexis 17243 (11th Cir.), finding that the facts alleged were sufficient to create a genuine issue as to whether an officer was deliberately indifferent to a "strong likelihood" that a DUI arrestee would commit suicide while in the city jail. In this case, the officer allegedly knew of the prisoner's past suicide attempt by attempting to slit her wrists only a month before, but failed to communicate to anyone else at the jail his belief that the prisoner was a strong suicide risk, and did not take the actions he himself said he would have taken with a prisoner regarded as a suicide risk, such as frequent checks on the prisoner, removal of

items from the prisoner's cell with which she could harm herself, or placement in a medical center for treatment and observation.

*Wever v. Lincoln County, No. 03-3633, 2004 U.S. App. Lexis 22974 (8th Cir. 2004), in which the appeals court ruled that a county sheriff was not entitled to qualified immunity to claim that he was deliberately indifferent in his training and supervision of personnel in dealing with the risk of suicide in a county jail where two prior suicides had occurred. In this case a detainee who threatened suicide was allegedly placed in an isolation cell and given a blanket with which he hung himself a half hour after making the threat.

* Gray v. Tunica County, Mississippi, #03-60761, 100 Fed. Appx. 281 (5th Cir. 2004). In this case, the court found that deliberate indifference to the risk that a detainee in a county jail would commit suicide was not shown where the jailer removed shoes and socks from the detainee's cell, had him placed in a padded "lunacy cell," and instructed personnel to place him on a suicide watch. Additionally, when the detainee was subsequently observed in the cell without clothes and in a "frog-like" position, a nurse was instructed to observe the detainee to assist in determining whether the cell should be entered, and it was concluded that the detainee was merely sleeping at the time. The fact that this conclusion was incorrect might show negligence, but not the deliberate indifference required for a civil rights claim.

It should be noted that, given that lawsuits over successful suicides involve a death, that when liability is found, or when the case is such that a settlement is reached, for whatever reasons, the damages can be substantial. See, for example:

*Price v. Black Hawk County, No. 00-CV-2008 (March 21, 2003, N.D. Iowa), reported in The National Law Journal, p. B2 (April 7, 2003), in which the estate of a manic-depressive schizophrenic prisoner with prior suicidal tendencies who committed suicide in his cell when left unattended reaches $300,000 settlement on federal civil rights lawsuit against sheriff and county. The plaintiff claimed that the decedent's need for psychiatric treatment or counseling was ignored, while the defendants argued that the decedent did not indicate a need for such care, but instead misled jail personnel about his medical history.

* Woodward v. Corr. Med. Services of Illinois, #03-3147, 2004 U.S. App. Lexis 9537 (7th Cir.), in which a federal appeals court upheld a wrongful death jury award of $1.75 million in an Illinois detainee suicide case based on alleged custom of failing to follow proper procedures with mentally ill inmates. In this case, a county jail detainee hung himself after telling jail medical workers that he was suicidal. The appeals court rejected the argument that the contractor could not be held liable because of the plaintiff's failure to introduce evidence of any prior suicide at the jail. The defendant, the court commented, does not get a "one free suicide" pass. Given the evidence, the court stated, the fact that no one in the past committed suicide simply showed that the contractor providing medical services was "fortunate, not that it wasn't deliberately indifferent." It did not avail the defendant to point to supposedly good policies on suicide prevention,

since the court stated that, "For all intents and purposes, ignoring a policy is the same as having no policy in place in the first place. "

*Jutzi- Johnson v. United States, #00-2411, 263 F.3d 753 (7th Cir. 2001), finding that a trial judge's award of $1.8 million in damages for suicide of pre-trial detainee in federal jail should be overturned because a suicide after six months of incarceration was not foreseeable when prisoner had no known prior history of suicide attempts or thoughts; additionally, an award of $1.6 million for pain and suffering while hanging to death was excessive when no reasoning for the award was offered by the court.

* Simmons v. City of Philadelphia, 947 F.2d 1042 (3rd Cir. 1991) finding a city and its officers liable for $1.104 million for failure to prevent suicide of intoxicated detainee. The court found that a city policy of inadequate training on suicide prevention established the basis for municipal liability.

Good steps to take to avoid such liability include training in suicide prevention for all correctional staff members, identification, to the extent possible, of detainees and prisoners at particular risk, through intake screening, procedures to refer prisoners with possible suicidal tendencies to mental health and other medical personnel, ongoing monitoring and assessment of those found to be at risk, good communication between medical treatment personnel and other correctional personnel (and vice versa), and good procedures for reporting and documenting what is done concerning prisoners at risk for suicide.

2. State law wrongful death lawsuits.

In many instances, plaintiffs have also asserted state law wrongful death or negligence claims against correctional agencies and employees, whether as additional claims in federal court, or as independent lawsuits in state court. While state case law varies greatly from state to state, some jurisdictions may allow for liability on a lesser standard than the "deliberate indifference" to a known risk of suicide required for federal civil rights liability, such as recklessness, willful and wanton conduct, or negligence. Issues of what correctional employees knew about a prisoner's suicidal intentions or tendencies are still relevant, however, and the issue of whether the suicide attempt was "foreseeable" is also often at issue.

Liability may also sometimes be based on the failure on the part of correctional employees to follow the requirements of either departmental policy or state law, which usually, standing alone, are not sufficient for federal civil rights liability. Various state law immunities may also be available to correctional employees, the scope of which will often determine whether or not there is liability in a particular case.

Some recent examples of state law cases concerning prisoner suicide which are of interest include:

* Middlebrooks v. Bibb County, 582 S.E.2d 539 (Ga. App. 2003), in which Georgia

county correctional facility personnel took steps to monitor prisoner known to be a suicide risk after he previously attempted to harm himself and were therefore not liable for his successful suicide in his cell which he accomplished by "unique methods," fashioning a tourniquet from a bed sheet and a crutch he had in his cell which he needed to walk after he broke his leg.

* Howard v. City of Atmore, No. 1021312, 887 So.2d 201 (Ala. 2003), as modified on denial of rehearing (2004), in which a police officer working as jailer in city jail was found not entitled to peace-officer immunity under Alabama State law on a claim against him by the sister of an inmate who committed suicide there. The officer allegedly failed to follow mandatory rules and procedures requiring him to check on the prisoner twice an hour, and therefore was not exercising discretion when he engaged in the conduct that allegedly led to the inmate's death. The court rejected, however, claims against the police chief based on training, implementing and enforcing procedures concerning the identification and handling of potentially suicidal prisoners.

* Harvey v. Nichols, No. A03A0568, 581 S.E.2d 272 (Ga. App. 2003), finding that a jail inmate's suicide was an unforeseen incident which could not be shown to have taken place because of the failure of officers to regularly conduct surveillance of his cell, when he acted "calm and controlled" before he took his own life, and his behavior did not show that he might be a danger to himself.

* Pennsylvania State Police v. Klimek, 839 A.2d 1173 (Pa. Cmwlth. 2003), holding that a detainee's action of hanging himself to death with shoelaces in his holding cell less than two hours after being placed there on DUI charges did not subject a facility to liability under Pennsylvania state law for negligence. Neither "personal property" nor "real estate" exceptions to sovereign immunity under state law applied.

* Shelburne v. Frontier Health, 126 S.W.3d 838 (Tenn. 2003), holding that a private psychiatric hospital and not-for-profit company which owned it were not immune under Tennessee law for potential liability for county jail inmate's suicide on the basis of their employee's alleged action in telling county jail that suicide protocol precautions were not necessary for this prisoner. The employee also qualified as a "state employee" because of his service in screening prisoners to determine if hospitalization was appropriate, and as a state employee, he was entitled to statutory immunity, but this did not alter the result as to the hospital or its owner.

* Clark v. Prison Health Services, Inc., #A02A1014, 372 S.E.2d 342 (Ga. App. 2002). The court found that, in a lawsuit for wrongful death based on prisoner's suicide which named health care provider as a defendant, the plaintiff did not have to comply with medical malpractice lawsuit requirement of submission of an expert affidavit of merit. Correctional officers who allegedly failed to follow jail policies for monitoring and inspecting the prisoner's cell were not protected by qualified immunity from wrongful death action, as their duty of inspecting the cells on a schedule was "clear and certain," rather than requiring the exercise of personal judgment.

* Quinn v. Estate of Jones, No. 2000-CA-00977-SCT, 818 So. 2d 1148 (Miss. 2002). Dismissal in federal court of wrongful death lawsuit brought over detainee's action of hanging himself in county jail, which included state law claims barred relitigation of the estate's wrongful death and negligence claims in state court.

* Cook v. Sheriff of Monroe County, No. 03-14784, 2005 U.S. App. Lexis 4014 (11th Cir. 2005), in this case, involving both federal and state law claims, a federal trial court was ruled to have properly granted judgment as a matter of law on federal civil rights claims and negligent training and supervision claims against Florida sheriff arising out of a detainee's suicide after his requests to see a psychiatrist failed to be granted. The appeals court also found, however, that the trial court erred in also granting judgment for the sheriff on a state law vicarious liability negligence claim. The trial court acted within its discretion in excluding evidence of other suicides at detention facility, and testimony of plaintiff's suicide expert witness.

* Brown v. Harris, No. 00-1127, 240 F.3d 383 (4th Cir. 2001). In a case involving both federal and state law claims, the appeals court ruled that constant video surveillance of a suicidal prisoner's cell was not "deliberate indifference" to the risk of him taking his life; correctional officials were therefore not liable for the prisoner hanging himself with his shoelaces. The appeals court further ruled there was no liability, under Virginia state law, for suicide in the absence of a showing that prisoner was of "unsound mind" when he took his own life.

3. Some Helpful Resources

Statistics: Suicide and Homicide in State Prisons and Local Jails. Describes historical trends in State prison and local jail inmate mortality rates based on inmate death records submitted by local jails (for 2000-2002) and State prisons (for 2001-2002). The report also compares current prison and jail mortality rates by demographic characteristics, offense types, and facility size and jurisdiction and compares the general population mortality rates with mortality rates in correctional facilities. Comparisons are made to both the raw mortality rates for the general population and those standardized to match the demographic makeup of the inmate populations. This report presents the first findings from the Deaths in Custody Reporting Program, which implements the Death in Custody Reporting Act of 2000 (P.L. 106-297). This new program involves the collection of individual records for every inmate death in the Nation’s local jails and State prisons. The program also includes the collection of death records from State juvenile correctional authorities (begun in 2002) and State and local law enforcement agencies (begun in 2003). Highlights include the following: * In 2002 the suicide rate in local jails (47 per 100,000 inmates) was over 3 times the rate in State prisons (14 per 100,000 inmates). * Homicide rates were similar in local jails (3 per 100,000) and State prisons (4 per 100,000). * Violent offenders in both local jails (92 per 100,000) and State prisons (19 per 100,000) had suicide rates over twice as high as those of nonviolent offenders (31 and 9 per 100,000 respectively). 08/05 NCJ 210036

American Indian Suicides in Jail: Can Risk Screening Be Culturally Sensitive? June 2005 [PDF] Do jail inmates' cultural backgrounds affect how they react to authorities' attempts to assess their risk for suicide? A recent National Institute of Justice (NIJ) study found that the screening questionnaire used by a county jail located near Indian lands failed to elicit direct responses about personal matters from American Indian detainees. Findings suggest that tailoring suicide risk assessment protocols to the cultural backgrounds of detainee populations might be more effective.

Program Statement: Suicide Prevention Program. No. P5324.05, U.S. Department of Justice, Federal Bureau of Prisons (3/1/2004). Sets forth programs designed to train all institutional staff to recognize signs and information that may indicate a potential suicide, prepare prison staff to act to prevent suicide with appropriate "sensitivity, supervision, and referrals," and provide any inmate clinically found to be suicidal with appropriate preventive supervision, counseling, and other treatment.

Prison Suicide: An Overview and Guide to Prevention, U.S. Department of Justice, National Institute of Corrections (125 pgs., .pdf format June 1995). Reviews prior literature concerning in-custody suicide, national and state standards for prison suicide prevention, prison suicide rates, effective suicide prevention programs in state prisons, suicide prevention in federal prisons, and the courts' role in shaping prison suicide policy.

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