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# JAIL SUICIDE LIABILITY: TRENDS, STANDARDS, AND CASELAW

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# [ Background ]

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- Suicide is impossible to predict with accuracy.
- Nonetheless, inmates who commit suicide in jail tend to share certain characteristics.
- By being aware of these characteristics, and examining your jail's policies and procedures, you may be able to decrease the risk that a suicide will occur in your jail.
- You may also be able to decrease the risk that the Sheriff's Office and individual jail officers will be found liable in the event a suicide does occur in your jail.

# [ Some statistics ]

- The third leading cause of death in U.S. prisons is suicide, following natural deaths and deaths from AIDS. Patterson & Hughes.
- Jails have a significantly higher suicide rate than prisons. In 2002, the suicide rate in U.S. jails was 47 per 100,000 inmates. In 2004, the suicide rate in U.S. prisons was 14 per 100,000.
- Approximately 85% of jail suicides occur by hanging. Men are 4 times more likely than women to commit suicide, and the highest risk group is non-Hispanic Caucasian men.

Patterson & Hughes, "Review of Completed Suicides in the Cal. Dept. of Corr. And Rehab., *Psychiatric Services*, Vol. 59, No. 6, June 2008, pp. 676-682.

# [ Some statistics (continued) ]

- Environmental stressors commonly reported by inmates who attempt suicide:
  - Isolation
  - Punitive sanctions
  - Severely restricted living conditions
  - Acquisition of new charges
  - Imposition of an unexpected sentence

Patterson & Hughes.

# [ Some statistics (continued) ]

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- In a 6-year study conducted of California jail inmates who committed suicide, researchers found that 73% of those inmates had a history of mental health treatment and 62% had a history of suicidal behavior or statements.

Patterson & Hughes.

# [ High risk categories ]

- Research indicates that inmates who fit the following categories may be at higher risk of committing suicide:
  - Inmates with a history of **mental illness**
  - Inmates with a history of **suicide attempts**
  - Inmates **housed alone**, in a single cell, such as in administrative segregation
  - Inmates who **express safety concerns**, who are also **anxious** and **agitated**
  - Inmates with **serious medical concerns**
  - Inmates whose **legal status has changed significantly** (for the worse)
  - **Caucasian** inmates

Patterson & Hughes.

# Illinois County Jail Standards

- Admission: Ill. Admin. Code tit. 20, § 701.40
  - Admitting officer required to observe a new detainee's general mental status and to determine by questioning whether the detainee has any indications of mental illness or developmental disabilities.
  - Also required to perform a mental health screening on a new detainee, or have a mental health professional perform one.
  - If a new detainee is known to have a psychiatric history or is exhibiting psychiatric symptoms the admitting officer must refer that detainee to health care personnel.
  - If the detainee is exhibiting suicidal ideations or behavior the admitting officer must also place that detainee in a reasonable level of care to provide for his or her safety.

# County Jail Standards (continued)

- **Classification and Separation:** Ill. Admin. Code tit. 20, § 701.70
  - A detainee/inmate's mental and emotional condition, and treatment needs, including a history of substance abuse, must be taken into account when determining where to house the inmate and the level of necessary security. § 701.70(a)(7), (8).
  - Detainees who are mentally ill, developmentally disabled or emotionally disturbed should be housed under supervision as recommended by a mental health professional. § 701.70(b)(6)(A).
  - And action should be taken to transfer such detainees to an appropriate facility if you determine that your facility is unable to care for the inmate. § 701.70(b)(6)(B)

# County Jail Standards (continued)

- **Mental health care:** Ill. Admin. Code tit. 20, § 701.90.
  - Jails shall **have a physician available** to detainees/inmates to attend to their medical and mental health needs 701.90(a), (b) and shall establish a daily sick call 701.90(d)
  - Jails shall provide a **medical screening** of all new inmates within 14 days of their arrival at the jail. 701.90(c)
  - Jails shall provide **annual mental health and suicide prevention training** to all jail personnel by professionals 701.90(h). Training should include recognition of verbal and behavioral cues, situational stressors and other signs of potential risk, monitoring, evaluation, stabilization, and referral of suicidal and mentally ill detainees/inmates.

# [ County Jail Standards (continued) ]

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- **Security:** Ill Admin. Code tit. 20, § 701.140
  - Jail sections housing persons who are suicidal, mentally disturbed or mentally impaired shall be given special care and supervision and checked more frequently than the standard 30-minute check. § 701.140(c)

**CASELAW:**

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**How Jailer's Actions Are  
Judged In The Courts**

# Possible claims

- FEDERAL CLAIMS:

42 U.S.C. § 1983: The estate of the deceased inmate can bring federal claims, on behalf of the decedent, pursuant to Section 1983 of the Civil Rights Act of 1871 for violations of the decedent's constitutional rights.

# [ Possible claims (continued) ]

- ILLINOIS STATE LAW CLAIMS:
  - SURVIVAL CLAIM: The estate of the decedent can bring a claim under the Illinois survival statute for injuries and pain suffered by the decedent prior to actual death.
  - WRONGFUL DEATH CLAIM: The estate of the decedent can bring a claim under Illinois state law for wrongful death on behalf of the decedent's next of kin for their sorrow, grief and expenses.
  - LOSS OF CONSORTIUM CLAIM: The spouse of the deceased inmate can bring a claim under Illinois state law for loss of consortium (*i.e.* companionship).

# Federal claims: Section 1983

- The 8<sup>th</sup> Amendment's ban on cruel & unusual punishments requires jail officials to take reasonable measures to guarantee the safety of inmates, which includes providing inmates with reasonably adequate medical care. *Farmer v. Brennan*, 511 U.S. 825 (Supreme Court 1994).
- Although the 8<sup>th</sup> Amendment applies only to convicted inmates, under the 14<sup>th</sup> Amendment pretrial detainees are entitled to the same basic protections as convicted inmates so courts apply 8<sup>th</sup> Amendment standards to pretrial detainees as well. *Frake v. City of Chicago*, 210 F.3d 779 (7<sup>th</sup> Cir. 2000).
- A section 1983 claim stemming from a jail suicide typically rests upon the allegation that the defendant jailers failed to provide the deceased inmate with adequate medical care (specifically, treatment of the inmate's suicidal condition).

## Section 1983:

### “Deliberate Indifference”

- To succeed on a claim for failure to provide medical care, a plaintiff must prove that the defendant was “**deliberately indifferent**” to an inmate’s need for medical attention.
  - First, the harm that befell the inmate must be objectively, sufficiently serious and a substantial risk to the inmate’s safety. This is always satisfied in a jail suicide case. *Collins v. Seeman*, 462 F.3d 757 (7<sup>th</sup> Cir. 2006)

# Section 1983:

## “Deliberate Indifference” (continued)

- Second, the defendant must have:
    - Subjectively known that there was a substantial and imminent risk that the inmate would commit suicide, and
    - Intentionally disregarded the risk.
- Novak ex rel. Turbin v. County of Wood*, 226 F.3d 525, 529 (7<sup>th</sup> Cir. 2000).

# Section 1983:

## “Deliberate Indifference” (continued)

Subjective knowledge of a substantial and imminent risk of suicide.

- This is not a negligence (“should have known”) standard – it requires **ACTUAL KNOWLEDGE**.

*Matos v. O’Sullivan*, 335 F.3d 553 (7<sup>th</sup> Cir. 2003).

- Factors that may show actual knowledge (if defendant was aware of them):
  - Inmate made suicidal statements
  - Inmate reported suicidal thoughts
  - Inmate recently attempted suicide or self-harm
  - Suicide screening form raises red flags

## Section 1983:

### “Deliberate Indifference” (continued)

- Other things to consider with respect to “actual knowledge”
  - Is the inmate mentally ill?
  - Has the inmate asked to speak to a counselor?
  - Is the inmate experiencing drug or alcohol withdrawal symptoms?
- While these factors, alone, may not be enough to impute actual knowledge of a suicide risk to jail officials, they have caused courts to scrutinize the actions of jail officials more closely.

# Section 1983:

## “Deliberate Indifference” (continued)

- Intentional disregard: the failure to take appropriate steps once suicide risk is known.
  - Failure to check on a suicidal inmate for an extended period of time. *Wells v. Bureau County*, C. D. Ill. 2010, inmate went nearly 8 hours without being visually observed.
  - Failure to refer a suicidal inmate to a counselor.
  - Failure to put a suicidal inmate on suicide watch. *Woodward v. Correctional Medical Services of Illinois, Inc.*, 7<sup>th</sup> Cir. 2004, inmate reported psychiatric history, history of suicide attempts, and current suicidal thoughts during intake screening but was placed in general population.
  - Failure to respond promptly when suicide is discovered. *Bradich v. City of Chicago*, 7<sup>th</sup> Cir. 2005, took officers 10 minutes to call for an ambulance.

# Section 1983: County Liability

- A municipal entity (*i.e.* Sheriff's Office) may be liable for a jail suicide under Section 1983 if the court determines that the entity's policies, or lack thereof, caused a violation of the inmate's constitutional rights. *Novack ex rel. Turbin v. County of Wood, 7<sup>th</sup> Cir. 2000.*
  
- Jail policies and procedures that your jail should have:
  - A suicide screening policy for new inmates and have a suicide watch policy for inmates who are known suicide risks.
  - All corrections officers should receive training on these policies.
  - Regular suicide prevention training for all corrections officers.
  - Jail policies should at least comply with Illinois County Jail Standards, although a violation of them does not necessarily give rise to civil liability.

# Section 1983: County Liability

(continued)

- If your jail has had multiple suicides or suicide attempts, courts will look closely at your policies, or lack thereof. Review your policies after a jail suicide and take appropriate steps to make sure it doesn't happen again.
  - If a new policy should be implemented, then implement it.
  - If an existing policy should be changed, then change it.

# Illinois State Law Claims

## SURVIVAL – WRONGFUL DEATH – LOSS OF CONSORTIUM

- When evaluating the conduct of jail officials for a state law claim, the court will use a test essentially the same as the federal “deliberate indifference” standard. *Williams v. Rodriguez*, 7<sup>th</sup> Cir. 2007.
- Significantly, the court will take into account the role that the decedent’s own conduct played in his death, unlike a section 1983 claim.
- Some of these claims (wrongful death and loss of consortium) can be brought by the inmate’s next of kin for their own pain and suffering.

# EXAMPLES: Summary Judgment granted

- **Rapier v. Kankakee County (C. D. Ill. 2002)**
  - Widow of inmate who hung himself while on suicide watch sued the county, alleging that the county was deliberately indifferent because it was aware the jail was overcrowded and understaffed, and that the suicide watch cell was improperly designed because it did not allow for constant visual monitoring of inmates.
  - The court rejected plaintiff's argument and found that the county had a suicide prevention policy (putting suicidal inmates in special cell and requiring observations every 15 minutes).
  - No detainee had ever committed suicide in the special cell before.
  - Accordingly, prior to Rapier's suicide, the county reasonably believed that its policy of placing suicidal detainees in the special cell and requiring 15-minute checks, was an effective way to prevent suicide.
  - County was not deliberately indifferent.

# [EXAMPLES: Summary Judgment granted]

- **Matos ex rel. Matos v. O'Sullivan (7<sup>th</sup> Cir. 2003)**
  - Inmate with a psychiatric history (bipolar, schizophrenic), prior suicide attempt, and history of drug abuse hung himself in his cell after reporting that he was depressed but not suicidal.
  - Inmate was evaluated by mental health care providers but not put on suicide watch.
  - Court found that jail officials had no actual knowledge that the inmate posed a high risk of suicide.
  - The fact that he was depressed is “neither surprising nor remarkable” in a jail setting.
  - The fact that he attempted suicide 3 years earlier and had a history of drug abuse was insufficient to impute actual knowledge of suicide risk to jail officials.

# EXAMPLES: Summary Judgment denied

- **Cavalieri v. Shepard (7<sup>th</sup> Cir. 2003)**
  - Detainee arrested after kidnapping his former girlfriend and then threatening to commit suicide.
  - While detainee was in custody, mother and girlfriend told Officer Shepard that detainee was suicidal and should be on suicide watch.
  - Shepard failed to communicate that information to the jail, although he assured the mother he would.
  - Shepard claimed that after interviewing the detainee, he did not believe he posed a suicide risk.
  - Detainee not put on suicide watch, hung himself with phone cord.
  - Court found that a jury could conclude that Shepard had knowledge of a substantial risk and was deliberately indifferent in failing to pass that knowledge on to jail officials.

# [ EXAMPLES: Summary Judgment denied ]

## ■ **Wells v. Bureau County (C. D. III. 2010)**

- 17-yr-old male taken into custody for possession of drug paraphernalia and consumption of alcohol.
- Although detainee had a recent history of suicidal threats, jail officials did not know this.
- Because jail was understaffed, Sheriff had reduced the frequency of overnight cell checks.
- As a result, detainee (who was housed alone) went nearly 8 hours without being visually observed, and then was found hanging in his cell.
- Individual officers, who were following Sheriff's policy, were not deliberately indifferent.
- Sheriff's policy, however, is subject to an objective standard, and may have been "deliberately indifferent to the known or obvious consequences" of having such infrequent cell checks.



**JURY VERDICTS  
AND  
SETTLEMENTS**

# Verdicts & Settlements

- The amount of damages awarded to a plaintiff in a jail suicide case can vary widely.
- EXAMPLES:
  - **\$33,500 settlement** in 2001 Michigan case where male inmate hung himself in cell with a bedsheet and defendants denied having any knowledge the inmate was suicidal. *Harris v. County of Kalamazoo*.
  - **\$250,000 jury verdict** in 1987 Illinois case where male recently arrested for DUI hung himself with bedsheet. *Ratkovic v. Kendall County*.
  - **\$350,000 jury verdict** in 1990 Illinois case where male detainee arrested for DUI hung himself in holding cell with his underwear. *Safian v. Vill. of Palatine*.
  - **\$370,000 jury verdict** in 1993 Pennsylvania case where male was arrested for public intoxication, hung himself in suicide prevention cell. *Estate of Fiorentino v. City of Philadelphia*.

# Verdicts & Settlements (continued)

- **\$635,000 settlement** in 2009 Wisconsin case where mentally ill woman had multiple prior attempts at self-harm and suicide in the same jail, another inmate warned guards that she was suicidal, they allegedly failed to monitor her and she hung herself. *Estate of Enoch v. Tienor*.
- **\$858,000 jury verdict** in 2006 California case where mentally ill female inmate hung himself. *Shaw v. San Joaquin County*.
- **\$1.75M jury verdict** in 2003 Illinois case where 23-yr-old male inmate reported being suicidal, was repeatedly evaluated by jail psychologist but not put on suicide watch, subsequently hung himself, and there was evidence that the medical care provider in the jail routinely ignored policies and procedures. *Woodward v. Correctional Med. Servcs. of Ill.*

# Verdicts & Settlements (continued)

- Large verdicts and settlements tend to occur in cases where the following factors are present:
  - Inmate was mentally ill.
  - Inmate was under the influence of drugs or alcohol or experiencing withdrawal.
  - Inmate reported suicidal thoughts to jail staff.
  - Inmate had attempted suicide in the jail on a prior occasion.

# Verdicts & Settlements (continued)

- Exceptionally high damage awards sometimes occur in cases where the inmate fails to commit suicide, but injures himself so severely that he will need around-the-clock medical care for the rest of his life.
  - **\$13.1M settlement** in 2007 Wisconsin case where female inmate with children left in vegetative state after hanging attempt. *Mombourquette v. Amundsen*.
  - **\$3.5M settlement** in 2004 Pennsylvania case where a 22-yr-old male detainee told jail staff about prior suicide attempt but was not put on suicide watch, and subsequently attempted to hang himself in his cell leaving him permanently disabled. *Foster v. City of Philadelphia*.



**PREVENTION  
AND  
TRAINING**

# [ Identifying suicide inmates ]

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Often when an inmate commits suicide, jail staff did not even recognize that the inmate was suicidal. Thus, effectively identifying suicidal inmates is crucial for preventing jail suicides.

# Identifying suicide inmates

(continued)

- Perform a mental health and suicide screening of all new inmates that arrive at the jail as soon as possible.
  - This screening typically involves completion of a questionnaire.
  - Train jail personnel to complete the form and administer its questions.
  - Train jail personnel to interpret not only an inmate's verbal responses (*i.e. suicidal statements, statements of hopelessness, etc.*) but also an inmate's nonverbal cues (*i.e. crying, appearing flat or withdrawn*) that may indicate suicidal tendencies.
  - If a new inmate's responses or demeanor indicate to jail staff that he or she may be suicidal, the inmate should be placed on suicide watch, referred to a mental health care provider (discussed below), and the shift supervisor should be notified.

# Identifying suicide inmates

(continued)

- Jail standards require that corrections staff receive yearly training on suicide screening and prevention. Make sure such training is provided.
  - If possible, bring in mental health professionals for the training so that they can provide their own expertise and answer any questions that jail staff may have.
  - This training helps jail staff interpret nonverbal cues that may demonstrate that an inmate is suicidal.
  - This training also helps jail staff identify whether any inmates (as opposed to just *new* inmates) are suicidal by interacting with them and observing their behavior.

# Handling suicidal inmates

If an inmate is determined to be suicidal, staff must be trained to take certain steps:

- Immediately place the inmate on suicide watch.
  - Put the inmate in a cell that is easily observable and designed to discourage suicide.
  - Observe the inmate more frequently than every 30 minutes. Typically, suicide watch entails 15 minute checks but the inmate should be checked more frequently if necessary.
  - Remove items that could be used to commit suicide (pens, pencils, bedsheets, regular jail uniform, etc.) and provide the inmate with a suicide-prevention gown and blanket.

# Handling suicidal inmates

(continued)

- Refer the inmate to a mental health professional for an evaluation.
- Ensure that each oncoming shift is informed that the inmate is on suicide watch.
- Do not remove the inmate from suicide watch until a mental health professional determines that the inmate is no longer at risk of committing suicide.

# [ Prevention, generally ]

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- Round on inmates every 30 minutes.
  - Many jail suicide cases involve situations where 30-minute rounds were not made, either because the jail was understaffed or because corrections staff just neglected to perform rounds.
- Pass your periodic jail inspections! If any problem areas are identified – correct them.



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**WHAT IF IT HAPPENS  
IN YOUR JAIL?**

# Provide medical care immediately

- Train and instruct jail staff to begin CPR and summon emergency medical care *immediately*.
  - Obviously, the immediate provision of medical care will improve the likelihood of saving the inmate.
  - Courts are highly suspicious of delays, even of just a few minutes, in the provision of emergency medical care. (*Bradich v. City of Chicago*, 10 minutes for officers to summon an ambulance; *Estate of Enoch v. Tienor*, responding officers had difficulty opening cell door and then shackled inmate before starting CPR)
  - All jail staff should be trained in CPR.
  - Have a portable defibrillator available, although it is not required by Illinois County Jail Standards. Train jail staff in the use of the defibrillator.

# [ Initiate an investigation ]

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- The Sheriff's Office should immediately launch an investigation into the suicide.
  - The investigation should be handled like any other Sheriff's Office investigation - by the Investigations Division - not Corrections.
  - Depending on the situation, the Sheriff's Office may want to have an independent agency (e.g., ISP) conduct an investigation.
  - Investigators should explore how the suicide happened and if it could have, or should have, been prevented.

# [ Investigation (continued) ]

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- Preserve all evidence immediately, including:
  - The instrument of suicide (bedsheet, telephone cord, etc.).
  - Any surveillance video of the inmate and the jail generally around the time of the suicide.
  - Audio recordings of radio traffic within the jail and the EMS call.
  - Any documentation or records pertaining to the deceased inmate (booking forms, medical records, etc.), including records from prior incarcerations.

# [ Investigation (continued) ]

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- Interview any Sheriff's Office personnel that had recent contact with the inmate.
  - What statements did the inmate make?
  - What was the inmate's demeanor?
  
- Establish a timeline of events.
  - Review the surveillance video and audio recordings.
  - Identify what each individual member of the jail staff was doing during the time period leading up to the suicide.

# [ Investigation (continued) ]

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- Review jail policies and procedures.
  - Did jail personnel comply with jail policies and procedures at all times?
  - Should jail policies or procedures be modified to prevent a similar incident in the future?

# [ Notify D.O.C. ]

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- Notify the Department of Corrections of the suicide within 72 hours and submit the requisite forms.
- Cooperate with D.O.C.'s investigation into the suicide.
- Make yourself available for an interview with D.O.C.
- Provide D.O.C. with any requested material such as video or audio recordings, or documents.

# [ Speak to the public ]

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- Hold a press conference at which a single speaker, preferably the Sheriff, informs the public that a suicide occurred in the jail and that an investigation is underway.
- Do not provide the media with any additional information while the investigation is ongoing.

# Identify the needs of your staff

- Sit down, individually, with your staff and discuss the incident.
  - Explore how your staff is coping and whether they have any concerns they want to discuss with you.
  - Be aware that your discussions with your staff, outside the presence of your attorney, can be discoverable by the plaintiff in subsequent litigation.

## [ The needs of your staff (continued) ]

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- Provide counseling and support to the jail staff that was on duty at the time of the suicide.
  - A jail suicide can have a significant psychological effect on the staff that was on duty when it occurred.
  - Make counselors available to jail staff as soon as possible.
  - The psychological effect can be lasting, so it is important that you follow-up periodically with your staff to see how they are coping.

# Biographies

- Michael W. Condon is a 1986 graduate of the John Marshall Law School, where he was the Executive Lead Articles Editor of the Law Review. For the past twenty-five years, Michael has represented public officials and various units of local government across the State of Illinois at both the trial and appellate levels. Michael has successfully tried numerous jury cases in federal court on behalf of police officers and their employers. In addition to his federal trial practice, Michael also has substantial experience in litigating administrative matters involving units of local government. He has successfully represented police chiefs and other officers in disciplinary proceedings before local Fire and Police Commissions.
- Michael D. Bersani received an undergraduate degree from the University of Illinois in 1985 and a law degree from The John Marshall Law School in 1988. Upon completing law school, Mike served as a judicial clerk to a state appellate court judge. He entered private practice in 1990 and has concentrated in representing local governments and public officials in civil rights litigation, including police liability, jail litigation, wrongful termination and employment discrimination.
- We would like to thank our associate, Kathleen M. McNamara, for her contribution toward preparation of the materials and research for this presentation.