

# **A&SN**

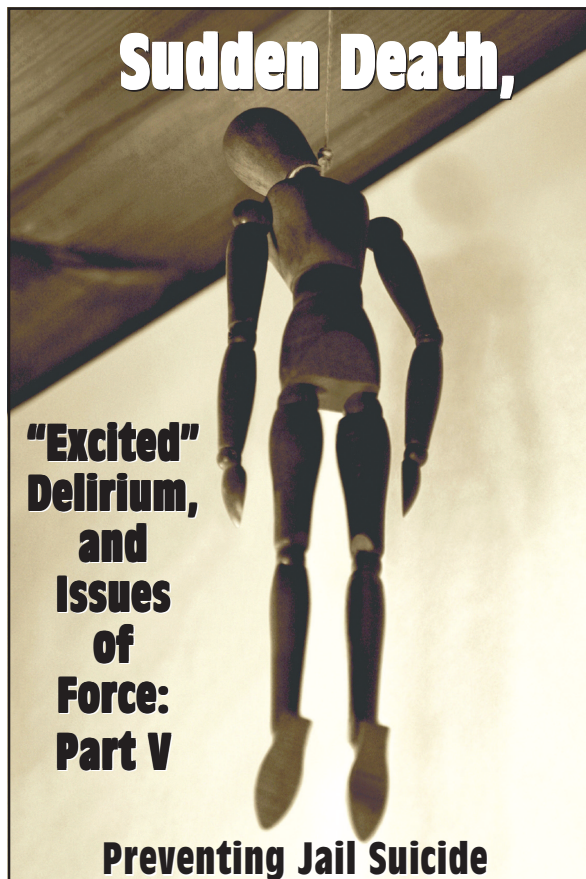
**POLICE AND SECURITY NEWS**

**THE INFORMATION SOURCE FOR  
LAW ENFORCEMENT AND HOMELAND SECURITY**

NOVEMBER/DECEMBER 2006

PUBLISHED BY DAYS COMMUNICATIONS, INC.

VOL. 22 ISSUE 6



Copyright 2006, John G. Peters, Jr. ARR

*By John G. Peters, Jr., M.B.A., Ph.D., CLS,  
and Teri Himebaugh, J.D., L.L.M.*

Part V focuses upon inmate suicide frequency; DICRA 2000; jail and prison suicide predisposing factors; and prevention protocols.

The sheriff's deputy served a warrant on a young husband and father at home and immediately transported him to the local jail. The young man had been there before, but neither the jailer nor the deputy recognized him. The last time he was in jail, the

young father threatened suicide, but this information was not available to, or was not accessible to, the jailer. This time, when he was placed into the non-suicideproof cell, the man committed suicide by placing a bedsheet over a breakaway coat hook which was on the cell wall. The coat hook, however, did not break away as designed. The young man asphyxiated himself and died while one jailer was eating his dinner and the other staff person was sitting in the intake area. Notably, this was the second reported jail suicide in this same local jail where an inmate had used the identical means of committing suicide: placing a sheet over a "breakaway" coat hook.

Although police lockup, jail and prison suicide (hereafter referred to collectively as "jail suicide") rates have significantly declined during the past 20 plus years, and are no longer the leading cause of inmate deaths in the United States, they still occur and are often what come to mind when the term "in-custody death" is heard. They are costly, too. It is not uncommon for a municipality to spend \$100,000-\$1,000,000 in judgments, settlements and legal fees and costs related to this type of litigation.<sup>1</sup>

### **Suicide Rates in Jails and Prisons in the United States**

The Bureau of Justice Statistics (BJS) recently published updated jail and prison suicide frequencies in the United States. In its August 2005 special report, *Suicide and Homicide in State Prisons and Local Jails*, Christopher Mumola, BJS Policy Analyst, noted that the inmate suicide rates significantly declined from 1983 to 2002, the last year data was reported. In 1983, 56% of inmate deaths were due to suicide versus 32% in 2002. The 2002 leading cause of death in prisons and jails was from natural causes. One possible reason for this change is the longer sentences of incarceration for offenders, and/or the "graying" of the inmate population. Although lower suicide frequencies were found, 2002 county jail suicide rates (47 per 100,000 inmates) were still three times that in state prisons (14 per 100,000 inmates).

The special report also noted that the suicide rate in the 50 largest jail systems in the U.S. was 29 per 100,000 inmates

<sup>1</sup> Defendants are usually responsible for their own legal fees and costs. However, since this type of litigation is brought pursuant to 42 U.S.C. §1983, if the estate of the decedent plaintiff inmate is successful in the lawsuit, he may additionally collect from the defendants on top of any award or settlement, the plaintiff's attorney costs and fees pursuant to 42 U.S.C. §1988. If the Defendants are successful in their litigation, they may collect their attorney fees and costs from the Plaintiff's estate, assuming the estate has any assets.

which is about one half that of other jails which reported 57 per 100,000 inmates.

### Small Jails Versus Large Jails

The data indicate that the size of the jail may play a role in jail suicides. In short, the numbers show that the smallest jails recorded the highest number of suicides. Consider these comparisons: Jails with fewer than 50 inmates had a suicide rate of 177 suicides per 100,000 inmates, compared to the rate of jails which had 2000 or more inmates – 32 suicides per 100,000 inmates. Data show that, on an average day in 2002, more than 40% of American jails housed fewer than 50 inmates. In contrast, approximately two percent of jails in the U.S. averaged a daily population of more than 1500 inmates.

### Jail Suicides: Gender, Age, and Race

The reported data makes clear that male inmates have a higher number of deaths *from all causes* than female inmates: 150 per 100,000 inmates versus 130 per 100,000, respectively. Gender, age, and race appear to be key variables regarding jail and state prison suicides.

Age is another important variable when it comes to jail suicide. In short, the data reflect that suicide rates per 100,000 inmates held increased with age; however, there is one exception: juveniles. The youngest inmates (those under 18 years of age) had the highest suicide rate in local jails – 101 per 100,000 inmates held. Over a three year period of time, inmates under the age of 18 committed 35 (about four percent) of the 918 reported suicides.

Regarding race, white jail inmates were six times more likely to commit suicide than African-American inmates, and three times more likely than Hispanic inmates. In state prisons, African-American inmates had the lowest suicide rates.

### Jail Suicide and Violent Offenders

At 92 suicides per 100,000 inmates, violent offenders committed suicide at a rate almost three times higher than nonviolent offenders (31 per 100,000 inmates). The following is a breakdown of those violent offenders who had the highest suicide rates: offenders held for kidnapping, 275; offenders held for rape, 252; and offenders held for homicide, 182. Surprisingly, drug offenders had the lowest suicide rate (92 per 100,000 inmates).

### Jail and State Prison Suicides: When Do They Occur?

The majority of jail suicides occurred during the first week the inmate spends in custody. Table One depicts the percent of county jail inmate suicides for the period 2000-2002 and the amount of time the inmate served prior to the suicide.

In contrast to the 48% of county jail suicides which occurred during the first week of being incarcerated, only seven percent of state prison suicides occurred during the first 30 days after being incarcerated.

### Jail and Prison Suicide: Time of Day and Location

Not too surprisingly, at least 80% of jail and prison suicides occur in the inmate's cell. Table Two, Jail and State Prison Suicide Time of Day and Location, depicts the percentages. Please note the local county jail percentages are for a longer period of time than the state prison data.

### Compare Agency Data

Whenever data are presented regarding a subject, it is important to know how your agency's data compare to the publicized national data. For example, your local jail data may be somewhat different than what is reported by the BJS. It is important, therefore, to know the local data so that a solid suicide prevention

## 2000-2002: Jail Suicides and Time Served

Time Served After Incarcerated	Jail Inmate Suicides Percentage
Same day	13.7%
Next day	9.0
2-7 days	24.9
8-14 days	9.6
15-30 days	7.7
31-60 days	10.6
61-180 days	14.0
181 days or more	10.4

Source: Mumola, 2005, p. 8.

training program can be developed using both local and national statistics. Although United States county jail and state prison suicide data have been studied for years, the data presented above were culled from a relatively new law which requires jails, prisons, and law enforcement agencies to submit information on every sudden and in-custody death. The law, which was passed in 2000, is the Death in Custody Reporting Act of 2000.

### Death in Custody Reporting Act of 2000

Becoming law in October of 2000, the Death in Custody Reporting Act of 2000 (Public Law 106-297) was attached as a grant requirement of the Violent Offender Incarceration and Truth-In-Sentencing incentive grant program. Reportedly, these grants have provided over \$2.5 billion to all 50 states and United States Territories since the program began in 1996. Each state receiving funds from this grant program must report under the Death in Custody Reporting Act of 2000 (DICRA).

DICRA requires states to do the following: “[R]eport on a quarterly basis, information regarding the death of any person who is in the process of arrest, is en route to be incarcerated, or is incarcerated at a municipal or county jail, state prison, or other local or state correctional facility (including any juvenile facility), that, at a minimum, includes:(A) the name, gender, race, ethnicity, and age of the deceased; (B) the date, time, and location of death; and, (C) a brief description of the circumstance surrounding the death.”

Several states have expanded the definition of what should be reported to include “fringe deaths,” which include, but are not limited to, any death while in physical custody; any death while in physical or practical restraint; death at a crime scene; death in transit; death during booking or intake; and death from lethal force. If your agency administration has failed to report such deaths, this is a violation of federal law, but there is no penalty for the failing to report these deaths. For more information about DICRA, please visit the BJS Web site at [www.bjs.gov](http://www.bjs.gov).

### Mental Health Issues

According to Jamie Fellner, Director of the United States Program of Human Rights Watch, “Prisons have become the nation's primary mental health facilities.” It has been reported that the rate of mental illness inside prison populations is three times higher than in the general United States population. Additionally, mental health budgets have been cut by governments in an effort to save money which caused the closing of mental hospitals across the United States. Unfortunately, reasonable alternatives to these

## Jail and State Prison Suicide Time of Day and Location

Variable	Local Jail: 2000-2002	State Prison: 2001-2002
Total number of suicides	918	337
Overnight (midnight-6:00 a.m.)	28.0%	24.7%
Morning (6:00 a.m.-noon)	9.5%	19.9%
Afternoon (noon-6:00 p.m.)	24.1%	30.4%
Evening (6:00 p.m.-midnight)	28.4%	25.0%
Inmate's cell/room	80.8%	86.6%
Temporary holding area	9.6%	4.0%
Common area	6.1%	3.0%
Outside the facility	2.3%	3.0%
Elsewhere	1.1%	3.4%

*Source: Mumola, 2005, p. 9*

enforcement defense attorney and former police officer, Elliot Spector, the United States Supreme Court has provided a standard for agency administrators to use in conducting a simple analysis in prioritizing training. "It simply requires training officers to identify tasks, the need to train in such tasks, and a determination as to whether failure to train is likely to lead to a constitutional harm," says the trial seasoned attorney. The analysis described in *Walker v. City of New York*, 974 F2d 293 (2nd Cir. 1992) is helpful as the court applied a three part test to determine whether the city was obligated to provide training specifically related to these claims:

- Do you know to a moral certainty that officers will confront a particular situation?
- Does the situation present a difficult choice or is there a history of mishandling by employees?
- Will the wrong choice frequently result in a deprivation of constitutional rights?

Attorney Spector also points to *City of Canton, Ohio v. Harris*, 489 U.S. 378, 109 S. Ct. 1197 (1989) in which the United States Supreme Court looked at the tasks which officers are required to perform. "The test for inadequacy of training revolves around the task that particular officers must perform. In order to determine a liability risk, the [agency] must first determine what jobs its officers do. After making that determination, evaluators must ask whether a failure to train their officers on how to perform these tasks will likely result in a constitutional violation. If the answer is 'yes,' then they must provide adequate training or face the risk of being sued under the Civil Rights Act."

Some administrators may claim they have no money to conduct a training program. "It will be no defense that we didn't have enough money. That defense was raised in the Bryan County case [*Brown v. Bryan County, Oklahoma*, 219 F3d 450 (5th Cir. 2000)], and failed to carry the day, and now they have far less money," noted attorney Spector at a recent Americans for Effective Law Enforcement (AELE) Civil Liability Workshop.

In determining whether a prison official has shown "deliberate indifference" to an inmate's health or safety, courts consider what a prison official *actually* knew rather than to what a reasonable official in his or her position *should have* known. Actual knowledge may be proven, however, by circumstantial evidence, if an excessive risk to the inmate's health or safety was so obvious that an official must have known about it.

For example, if a correctional officer sees signs of presuicidal depression in an inmate under his (or her) supervision, but fails to appropriately document and act on that knowledge and the inmate commits suicide, the officer can be found liable. Thus, it is important that the staff be familiar with the common signs of presuicidal depression.

### Jail Suicide Training and Agency Policy

Developing jail suicide training and policy is a *process*, not a project. It is ongoing and should not be treated as a onetime task, and then put on the shelf. Agency policy will most often include tiered levels of suicide watch. Examples include, but are not

closings and/or understaffing of such institutions were not provided. This has resulted in many people who have mental illness not receiving treatment. When these people act out on the community streets, they are often arrested and then incarcerated.

Many of the behavioral cues which were identified and discussed in Part III for individuals who are at a high risk for sudden or in-custody death outside of a jail or prison are also found inside jails or prisons. Research identifies such behaviors as ranting and raving, babbling incoherently, talking to invisible people, self-mutilation, attempting suicide, etc. Many times when inmates demonstrate one or more of these behaviors, they are put into segregation or a special section of the jail or prison.

### Jail Suicide: Predisposing Factors

In addition to the age, gender and ethnicity considerations explored above, predisposing factors include, but are not limited to, evidence of alcohol and/or illicit and/or prescription drug use; history of depression; delusional behavior; history and/or family history of attempting suicide; a history of physical, sexual and/or substance abuse; hallucinatory behavior; discussion of guilt or shame over the offense, arrest, etc.; loss of job, family, money, loved one which may cause depression; and any statement such as, "You'll be sorry when I'm dead," even if you think it may have been made in jest.

### Jail Suicide: Behavioral Cues

Individual behavioral cues of suicidal intent include, but are not limited to, signs of depression, paranoia, delusions, aggression, strong agitation and/or sudden mood and behavioral swings; history of being under psychiatric care; sleeping excessively or insomnia; social withdrawal; self-mutilation or other attempts to harm oneself; giving away or packing of personal items, even if not being released; suddenly acting calm after signs of severe agitation or distress (may have peace about impending suicide); admission of prior suicide attempts; refusal of medical treatment for an illness or injury; and loss of appetite/weight.

The motives for suicide can be found in a previous *Police and Security News* article about suicide by cop, and is available online, or at [www.ipicd.com](http://www.ipicd.com). Because of space boundaries, these motives will not be listed or discussed in this article.

### Minimizing Liability for Jail Suicides

One method to minimize potential civil liability is to develop and implement an ongoing training program focusing on the prevention of jail suicide. According to nationally recognized law

limited to, full suicide watch with constant one-on-one observation of the inmate who is in a suicide prevention/strip cell by trained correctional or medical staff; observation of, and communication with, the potentially suicidal inmate in a suicide prevention and/or strip cell at random intervals, not to exceed 15 minutes between checks; and/or, observation of, and communication with, the potentially suicidal inmate in a suicide prevention and/or strip cell at random intervals, not to exceed 30 minutes between checks. Of course, a major component of any policy and training program is the development and use of a reasonable intake process and procedure which helps identify potentially suicidal inmates.

Emergency response to suicide training includes, but is not limited to, a means by which an emergency request for assistance can be immediately made; emergency supplies securely located on each level, such as scissors to cut any ligatures and tourniquets to temporarily stop arterial bleeding until paramedics arrive; CPR units available and easily accessible on each level; staff on each level who are properly trained and given periodic refresher training in emergency resuscitation procedures, including CPR.

Policies and training which focus on communication between (and among) departments within the facility and also between (and among) correctional officers and inmates are essential. Sharing important information about potentially suicidal inmates with other departments within the facility, such as medical or psychological, is critical to them getting the best care possible. Some of the potentially suicidal inmates may be covered by the Americans with Disabilities Act so policies and training on how to process and handle them are critical to minimizing agency liability.

Some administrators and supervisors may be reluctant to share information with other individuals and/or departments within the agency because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA; Public Law 104-191). Generally, however, police, firefighters, and other law enforcement agencies are not considered covered entities under HIPAA, and there are exceptions to the sharing of medical and psychological information


between units and people. Please check with your agency legal counsel for more information.

Additional information regarding cases and articles about jail suicide liability can be found at the AELE Web site at [www.aele.org](http://www.aele.org) and the Institute for the Prevention of In-Custody Deaths, Inc. Web site at [www.ipicd.com](http://www.ipicd.com).

### Summary

Suicide prevention is the responsibility of every employee who comes into contact with an arrestee and/or inmate. Policies and training can help to minimize liability, but there is more. It should not take policies or training to identify that a coat hook attached to a jail cell wall, or a doorknob protruding from the inside of a holding cell door which was formerly a closet in one police agency, is dangerous and is inviting liability. Liability assessment should be conducted by employees and items which are dangerous removed from cells, regardless if they were approved by the architect and/or the municipality.

*About the Authors: John G. Peters, Jr., M.B.A., Ph.D., CLS, is President and Chief Learning Officer of the Institute for the Prevention of In-custody Deaths, Inc., and principal of John G. Peters, Jr. & Associates, both of Henderson, Nevada. A Certified Litigation Specialist in police liability, corrections liability, and public employment liability, he has also been judicially qualified as an expert witness in law enforcement matters, including jail suicide. Your questions and comments are appreciated, and can be sent to him by visiting the IPICD Web site at [www.ipicd.com](http://www.ipicd.com).*

*Teri Himebaugh, J.D., L.L.M., is a licensed, practicing attorney who specializes in plaintiff's civil rights litigation, specifically prisoner civil rights and police misconduct cases, as well as criminal felony appeals. She presently serves as Vice President of the Eastern District of Pennsylvania Civil Litigation Fund and regularly teaches prisoner civil rights litigation to lawyers and judges on behalf of the U.S. District Court for the Eastern District of Pennsylvania. She has litigated numerous prison and jail suicide cases and has taught nationally on the topic. *