SUICIDE LITIGATION: COMMON PROBLEMS SEEN IN TRAINING, ASSESSMENT, HOUSING, OBSERVATION AND REFERRAL

BY

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TEXT

Recently a colleague asked: What common problems regarding jail operations are brought to light in jail suicide litigation?

Having been an expert in over fifty suicide cases litigated nationwide I have a unique perspective on how suicidal prisoners are handled in jails, the common failures in meeting the required standards of care, and the issues upon which litigation focuses. Unfortunately what I see in nearly all cases is a pattern or failure to adhere to accepted correctional practices resulting in plaintiff awards. Specifically, most jail suicide litigation focuses on problems related to correctional officer training, and the assessment, housing, observation and referral of suicidal prisoners. While suicides still occur in jails which have adopted standards and accepted practices, and litigation proceeds, the claims against these jails in federal civil rights cases usually fail, and state tort claims are minimized.

It difficult to assess the prevalence of jail suicide as no national reporting system exists, no studies have been initiated since those funded by the National Institute of Corrections in the early and mid 1980s, and state reporting requirements are spotty at best. (1) Additionally, those state reporting systems which exist do not generally require reporting of suicide attempts, nor do they chronicle potential suicides which have been prevented through proactive management and jail operations.

It is also difficult to assess to what extent nationally jail officials have developed policies and procedures, and trained officers on the proper methods of assessment, housing, observation and referral of potentially suicidal prisoners. One would expect that ACA accredited jails, or those medical programs accredited through the National Commission on Correctional Health Care (NCCHC) would have suicide prevention programs that meet contemporary standards and accepted practices. Of the approximately twenty five states with jail standards most address suicide to some extent. But other than Texas, which has aggressively addressed the issue, state standards programs fall short of the requirements of national standards in the critical areas of training, assessment, housing, observation and referral. (2)

What then, are the common areas encountered in jail suicide litigation, which if addressed, could lessen the potential for suicide and mitigate losses? Below is a discussion of the common problem areas with a review of relevant standards and practices which should be in place for the purpose of diminishing suicides.

TRAINING AND ASSESSMENT

Most jails use some form or another of suicide assessment. Typically, and inadequately, most jails use a form requiring the officer to fill in a blank which simply lists "suicidal" with a "yes" or "no" response. Others are a bit more detailed and may ask if the prisoner has a history of suicide. These forms, too, are inadequate.

In addition to the inadequacy of the forms currently in use in most jails most officers do not know how to identify a potentially suicidal prisoner. And when asked in depositions they usually admit to no training in suicide identification and say they fill out the form simply because it is procedure to do so. This sad fact of correctional practice contrasts rather dramatically with an officer's skill at filling out property inventories. Jail officers typically receive more training in property inventory than they do in suicide identification (if they get any at all) and spend more time on property inventory than they do in assessing suicide risk.

The NCCHC Standards for Health Services in Jails (1996) is the principal authority for assessing suicide risk. (3) Standard J-30 "Receiving Screening" requires medical screening to include assessment of suicide risk immediately upon arrival at the facility. (4) The screening takes two forms: recorded observation of the prisoner's health and behavior, and recorded answers to health related questions. In conjunction, Standard J-51, "Suicide Prevention" addresses the components of a suicide identification program. (5) It refers to a specific form in Appendix F of the standards manual which should be used in the risk assessment. (6) The form, adapted from the New York Commission of Correction Office of Mental Health, consists of seventeen questions and a rating scale to assess suicide risk. The form comes with instructions for the officer which could serve as the basis for training intake officers on the form's use.

Suicide risk assessment can be accomplished by correctional officers, however they must be trained in the assessment process. More critically, jail managers need to recognize the importance of establishing policy in this area, refer to the NCCHC standards in doing so, adopt the screening form recommended in the standards manual, and train staff.

Use of the NCCHC form or one similar to it and the training of officers will not necessarily ensure the identification of each suicidal prisoner. However, it will satisfy the duty of the jail officer to his prisoner in this critical area of assessment, mitigate against successful lawsuits, and provide for a safer environment.

HOUSING AND OBSERVATION

Most often where a prisoner has been identified as a suicide risk, jail policies generally call for placement in an observation area and the prisoner is placed on a fifteen minute watch. For high risk persons such placement is appropriate, however the fifteen minute watch may be inadequate.

Housing placement is critical for the identified suicidal prisoner. It should be in an area readily accessible to the jail officer, and should facilitate visibility. Observation augmented by video camera is acceptable; however the availability of video often is relied upon and substituted for personal observation and communication. Video often is the only source of observation used by jail officers. I know of two cases where a prisoner who was identified as a suicide risk and who committed suicide was observed on video in excess of three hours with a ligature around the neck—dead the entire time! In both instances video was relied upon as the sole method of observation and, in one case, there was a tape recording of the event which did not play too well to the jury.

Separate housing is a problem in most older jails as they were not built with cells for special needs prisoners. This problem needs quick solution as suicidal prisoners and others with infectious diseases or those under the influence need to be separated from the general population and need to be in an area where they can be observed. The solution need not necessarily cost a lot of money and may be achieved with a bit of creativity by jail staff, once they recognize the problem and see the need for special housing. The cost to do so is far offset by the costs of litigation and the pain of being accused of not doing something to save the life of a suicidal prisoner.

Observation is also a real problem for most small jails as they are often staffed with one person who in many cases is a dispatcher. To argue that the costs to provide adequate staffing in small jails is prohibitive is not legitimate in suicide litigation; in fact, it highlights the county's negligence to provide a safe environment and can even be evidence of a policy of deliberate indifference to a known risk.

The fifteen minute watch, which is more often the rule than not, is inadequate for severe suicide risks. The reason for this is that it takes as little as four minutes for a

person to commit suicide by asphyxiation by tying a ligature around the neck and placing ten pounds of pressure on the carotid artery. If a person is intent upon suicide then it should be obvious that the fifteen minute check falls short.

NCCHC PROTOCOLS FOR OBSERVATION, HOUSING AND REFERRAL

NCCHC has developed "Sample Suicide Prevention Protocols" which can be used as the basis for developing policies and guidelines for any jail, small or large, for the observation and housing of potentially suicidal prisoners. (7) Incorporating these protocols into policy, training of staff, and ensuring that referrals are made to mental health authorities should minimize liability in any litigation, but more importantly should provide for a safe environment for suicidal prisoners and should reduce the likelihood that they will commit suicide.

The protocols identify four levels of observation:

LEVEL ONE: This level applies to a person who has actually attempted suicide recently, requires that a psychiatrist be notified and placement in a mental health facility be initiated. It requires that the inmate be placed in a safe room or in a health clinic. Observation should be constant, one to one, while the inmate is awake and every five to ten minutes when he is sleeping. A safe room is described in the protocols as one where potentially harmful objects are removed, with no access to breakable glass or electrical outlets, no bed but a mattress for the floor and no protruding pipes.

LEVEL TWO: This level applies to prisoners who are considered high risk for suicide. Like Level One, a psychiatrist should be notified and efforts made for placement in a mental health facility. Safety room precautions need to be taken as in Level One. The person should be observed at least every five minutes while awake and at least every ten minutes while sleeping. He should have one-to-one observation when out of his cell, if he is in his cell and appears to be unusually distraught,or if potentially harmful objects are brought into the cell.

LEVEL THREE: This level applies to prisoners who a physician or psychiatrist determine are at moderate risk for suicide. The prisoner may have been one who was previously on Level One or Two and is improving. This level requires safety precautions such as searches of rooms and clothes for removal of potentially dangerous objects. Bed and linens are allowed. The prisoner should be checked visually at least every ten minutes while awake and every thirty minutes while sleeping.

LEVEL FOUR: This level is for prisoners who are at risk for severe depression or suicide. This prisoner may be housed in general population but correctional staff should be aware of his condition and should observe him for symptoms of depression and signs of suicidal ideation. Medical staff should be notified if conditions warrant. He should be checked every thirty minutes while asleep or awake.

The protocols note that a prisoner's condition may vary greatly from day to day, even hour to hour, thus requiring staff to have knowledge of the signs and symptoms of suicide as well as having good observation skills. They note that if staff have any reason to suspect that the prisoner should be moved to a higher level of observation the medical department should be notified and mental health people consulted.

Note that the protocols require the involvement of medical and mental health staff in the treatment and decision making about the housing and observation of suicidal prisoners. This important connection cannot be overlooked and properly identifies and limits the responsibility of trained correctional officers to assessment, observation and housing until the medical or mental health staff get involved. It is not the responsibility of correctional officers to treat the suicidal prisoner nor to make decisions as to when the prisoner should be taken off suicide watch. While the correctional officer may continue observation of the prisoner he does so at the direction of the mental health professional.

NCCHC PROTOCOLS AND SMALL JAILS

Possibly the greatest challenge to implementing the NCCHC protocols is to the staff of small jails.

One could easily dismiss the protocols as not applicable to the small jail or the rural county which may not even have the availability of mental health professionals. To this, one can only assert that the protocols are the most practical way to address the housing and observation of suicidal prisoners, and will need to be modified or altered to address local situations or conditions. It will require the jail manager to reach out to the medical and mental health community for assistance in massaging these protocols to fit the local situation.

As far as the observation requirements for a small jail with limited staff, this problem may be solved by use of trained community persons (perhaps retired volunteers) or even trained prisoners until medical care can be accessed.

This much is clear. Whenever litigation results from a suicide, these protocols will be used as measures of the jail manager's policies and practices, and the actions taken by jail staff in providing for a safe environment.

Any good faith attempt to implement these protocols, and train staff in methods of observation certainly provide a powerful argument against a deliberate indifference claim. And, staff's adherence to the protocols in managing a suicidal prisoner will provide a powerful argument against any state negligence claim.

OVERCOMING THE DISSONANCE BETWEEN POLICY AND PRACTICE

It is most usual in suicide litigation to find that there is a wide difference between planned or official policy and actual practice. The reasons for this are often that: "model"

policies and procedures are adopted but never shared down the line; managers are sincere in developing policies but fail to train their officers; and, they do not make the policies available to them. Whatever the reason, when the suicide is litigated and officers are deposed they express ignorance of the policy and profess to never having been trained.

This dissonance between policy and practice leaves jail managers vulnerable to liability, because not only is it obvious that they knew about the risk of suicide, but they failed to direct and train their staff in this critical jail operation.

CONCLUSION

Jail suicide is a rare phenomenon yet it presents the greatest incidence of death in custody. The prevention of most suicides is possible if jail managers connect the links between developing policy in the essential areas of assessment, housing, observation, and referral, and train staff in such policies. The best source for developing this policy is the standards of NCCHC.

In spite of a jail manager's best efforts in developing policy and training staff, suicides may still occur and litigation is sure to follow. But the chances for successful litigation are minimized when policy and training addressing contemporary correctional practices are in place.

ENDNOTES/SOURCES

1. Hayes, Lindsay M. and Joseph R Rowan, National Study of Jail Suicides: Seven Years Later, National Center on Institutions and Alternatives. Alexandria, Virginia. 1988.
2. Minimum Jail Standards, "Health Services", Chapter 273 "Health Services", paragraph .5 "Suicide Prevention Plan". Texas Jail Standards Commission, Austin Texas. 1996.
3. Standards for Health Services in Jails, National Commission on Correctional Health Care. Chicago, Illinois. 1996.
4. Ibid. pp. 41-43.
5. Ibid. pp. 65-67.
6. Ibid. pp. 149-150.
7. Ibid. pp. 151-152.

OTHER: Hayes and Rowan, Training Curriculum on Suicide Detection and Prevention in Jails and Lockups, NCIA. 2nd ed., March 1995. Available from the NIC Information Center, Longmont, Colorado. 1-800-995-6429.

AUTHOR'S NOTE: For purposes of this article the NCCHC standards and protocols have not been included in their entirety. Any policy and training developed for suicide assessment, housing, observation and referral should use the NCCHC manual as its basis, not this article.

TO THE EDITOR: QUOTES FOR HIGHLIGHTING

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