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JAIL SUICIDE UPDATE

Summer 1989 Volume 2, Number 2

NATIONAL STANDARDS OF JAIL SUICIDE PREVENTION

Beginning in the early 1800's and continuing today, various legislative bodies and agencies have examined local jails in an effort to fashion standards for the efficient operation of correctional facilities. From these efforts, two basic types of standards have emerged to measure the adequacy of jail conditions: 1) The minimum standards of constitutional decency devised and refined by federal courts in decisions challenging the conditions of confinement, and 2) The growing body of self-regulatory standards and accreditation procedures promulgated by professional and federal executive agencies to stimulate facility improvement through voluntary, administrative action.[1]

Not surprisingly, courts have taken an active role in measuring the adequacy of jail conditions. Standards have become a yardstick of measurement. As noted several years ago by the National Institute of Justice: " Not surprisingly, the new judicial activism has added a sense of urgency to the development of increasingly ***specific self-regulatory standards*** by executive and professional organizations. In turn, the availability of these standards promises to introduce a new level of objectivity to litigation challenging the conditions of confinement."[2]

Why the need for standards? Experts offer three basic reasons: 1) Promoting humane conditions of confinement; 2) Liability reduction in the event of a lawsuit; and 3) Organizational efficiency and the desire to professionalize the field of corrections. According to Thomas F. Lonergan, a well respected jail monitor in several federal jurisdictions, "The move toward professionalism in the field has been going on for many years, but comprehensive standards were not forthcoming until the early 1960's. Standards then represent a quantum leap in the move toward professionalism, and cover such topics as personnel, administration, and operations."[3]

In regard to liability reduction, Lonergan states that, in attempting to manage a correctional agency, a jail administrator is faced with the dilemma of what constitutes sound management practices, as well as what is representative of the "state of the art." Standards, whether national or state, can provide such a mechanism for the administrator. When devising a liability reduction strategy, the administrator can raise compliance with national and/or state standards as part of a good faith defense. Since such standards are reflective of the state of the art, they provide reasonable and minimal guidelines from which the administrator can design policies and procedures.

By their very nature, standards are "an effective tool by which detention facility administrators and local government officials can improve their physical facilties, avoid past jail design and construction errors, professionalize their management and operational procedures and staff, and provide services and programs required to adequately respond to inmate needs. Thus, the local detention facility will become an active, contributing participant in the contemporary correctional process of a community. Continued efforts to achieve these goals will attract greater legislative, executive and judicial government support providing basis for the improvement of detention and correctional systems."[4]

Correctional standards, however, are not legally binding and do not set constitutional requirements *(See Rhodes v. Chapman,* 452 U.S. 337 (1981); *Hoptowit v. Ray,* 682 F.2d 1237 (9th Cir. 1982); *Union County Jail Inmates v. Dibuono,* 713 F.2d 984 (3rd Cir. 1983); and *Peterkin v. Jeffes,* 661 F.Supp. 895 (D.C. Pa. 1987). The U.S. Supreme Court has ruled, however, that while not setting a constitutional minimum, national standards do have the ability to serve as guidelines or benchmarks in assessing the "duty of due care" or "reasonable conduct" [see *Bell v. Wolfish,* 441 U.S. 520 (1979)].

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National Standards of Jail Suicide Prevention

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Prison Suicides in Maryland

American Medical Association

The relationship between suicide prevention and correctional standards is a fairly recent phenomenon, and their alliance is worthy of examination. The first correctional standard to address suicide prevention was the American Medical Association (AMA)'s *Standards for Health Services in Jails.* The preface to the *Standards'* 1979 edition stated: "Studies show that the most frequent cause of death in jails is suicide, frequently alcohol and/or drug related, and secondly, withdrawal from alcohol and drugs independent of medical supervision." [5]

The receiving screening section of the *Standards* was expanded in the 1981 edition to include the following:

> . . .it is considered extremely important for ***booking officers to fully explore the inmate's suicide*** and/ or withdrawal potential. Reviewing with the inmate any history of suicidal behavior and visually observing the inmates' behavior (delusions, hallucinations, communication difficulties, speech and posturing, impaired level of consciousness, disorganization, memory defects, depression or evidence of self-mutilation) are recommended. Most jails following this approach, coupled with the training of all jailers regarding mental health and chemical dependency aspects, ***are able to prevent all or most suicides*** and 'cold turkey withdrawals.'[6]

American Correctional Association

The American Correctional Association (ACA)'s *Standards for Adult Local Detention Facilities* are the most widely recognized national correctional standards. The *Standards* were promulgated for both detention (more than 48 hours) and holding (less than 48 hours) facilities. The second edition, published in 1981, included sections on the screening and supervision of suicidal inmates:

> **2-5174** Written policy and procedure require that all high and medium security inmates are personally observed by a correctional officer at least every 30 minutes, but on an irregular schedule. ***More frequent observation is required for those inmates who are violent, suicidal,*** mentally disordered or who demonstrate unusual or bizarre behavior (Detention-Essential, Holding-Essential).
>
> **2-5273** Written policy and procedure require medial screening to be performed by health-trained staff on all inmates upon arrival at the facility. The findings are recorded on a printed screening form approved by the health authority. The screening process includes at least the following procedures:
>
> Inquiry into
>
> Current illness and health problems, including dental problems, venereal diseases and other infectious disease
>
> Medications taken and special health requirements
>
> Use of alcohol and other drugs which includes types of drugs used, mode of use, amounts used, frequency used, date or time of last use and a history of problems which may have occurred after ceasing use (e.g., convulsions)
>
> ***Past and present treatment or hospitalization for mental disturbance or suicide***
>
> Other health problems designated by the responsible physician.[7]

In 1983, Section 2-5174 of the ACA *Standards* was revised to state:

> **2-5174** Written policy and procedure require that all high and medium security inmates are personally observed by a correctional officer at least every 30 minutes, but on an irregular schedule. More frequent observation is required for those inmates who are mentally disordered or who demonstrate unusual or bizarre behavior: ***suicidal inmates are under continuing observation.***[8]

The following year, however, the suicide prevention section of the ACA *Standards* was further revised to include the strongest ACA commentary to date:

> **2-5271-1** Added August 1984. There is a written suicide prevention and intervention program that is reviewed and approved by a qualified medical or mental health professional. All staff with responsibility for inmate supervision are trained in the implementation of the program.
>
> **DISCUSSION:** Staff have a responsibility for preventing suicides through intake screening, identification, and supervision of suicide-prone inmates. They should receive special training in the implementation of a suicide prevention program.[9]

The ACA has recently published (July 1989) two additional standards manuals — *Standards for Small Jail Facilities and Certification Standards for Health Care Programs.* The *Standards for Small Jail Facilities,* developed for facilities housing 50 or less inmates, includes prior ACA Sections 2-5174 and 2-5273, but does ***not*** require 2-5271-1 — detailing the written suicide prevention program. ***All*** these sections, however, are included within the *Certification Standards for Health Care Programs,* designed to provide jail

administrators the opportunity to upgrade health care programs in their facilities.

Commission on Accreditation for Law Enforcement Agencies

In 1983, the Commission on Accreditation for Law Enforcement Agencies (CALEA) produced *Standards for Law Enforcement Agencies.* Chapter 72 of the *Standards* was devoted to short-term holding facilities (not exceeding 72 hours). In addition to receiving screening, the CALEA *Standards* promulgated two sections pertinent to suicide prevention:

> **72.5.4** A written directive prescribes methods for handling and detaining persons under the influence of alcohol or narcotics or who are violent or self destructive.
>
> **Commentary:** The holding facility is not normally equipped to provide appropriate treatment to intoxicated or drug-addicted arrestees, and such persons should be detained in other facilities, when available. When these facilities are not available, special consideration should be given to ensure that the potential for arrestees to injure themselves or others is minimized. Arrestees should be under observation ***at all times*** by facility staff.
>
> **72.10.2** A written directive requires that each arrestee is ***personally*** observed by agency staff at least every 30 minutes.
>
> **Commentary:** Care should be taken during physical checks that the arrestee does not anticipate the appearance of agency staff. Arrestees classified as high or medium security risks should be under closer surveillance and may require more frequent observation. This classification includes not only arrestees who are violent but also those who are suicidal, mentally ill, or demonstrate unusual or bizarre behavior.[10]

The CALEA *Standards* were revised in 1987. It should be noted the Section 72.5.4 was numerically changed to 72.5.6 and "at all times" was ***removed*** from the commentary. In addition, Section 72.10.2 was numerically changed to 72.8.2 and "personally observed" changed to "visually observed."

American Public Health Association

In 1986, the American Public Health Association published *Standards for Health Services in Correctional Institutions.* The manual, designed for both prisons and jails, offered specific standards relating to suicide prevention:

> Suicide is the major cause of death among detainees and prisoners. Health providers must be trained to recognize warning signs and must devise appropriate plans to safeguard life. Inmates are especially at risk for suicide when first admitted to a jail. Whereas correctional authorities have responsibility for safe custody, health staff possess the training and expertise to recognize signs of depression and aberrant behavior, which may include suicidal intent.
>
> A. ***Every correctional facility must institute a suicide prevention program which addresses the profile of inmates at greatest risk for suicide and details particular plans for intervention.***
>
> B. Jail health providers must screen inmates for suicidal intent or ideation as part of the admission medical evaluation, since 50 percent of jail suicides occur in the first 24 hours and 27 percent occur during the first 3 hours.
>
> C. Prison health staff shall screen inmates for suicidal intent on admission to the institution or transfer to another facility.
>
> D. When an inmate at risk is identified by medical staff, the inmate must be referred to the Mental Health Unit for immediate evaluation. Upon psychiatric evaluation, any inmate considered to be an actual suicide risk shall be hospitalized on an emergency basis. All others shall be placed in a mental observation area with a suicide watch pending further evaluation by a psychiatrist.
>
> E. Isolation may increase the chance that an inmate will commit suicide and must not be used as a substitute for staff supervision, especially in jails, especially for intoxicated individuals. A drug and/or alcohol-intoxicated prisoner shall not be locked in an unobserved cell or holding unit. Observation of intoxicated inmates must be constant. If observation is carried out via TV monitor, staff must be able to gain access to the prisoner within three minutes.
>
> See "And Darkness Closes In. . .National Study of Jail Suicides." The National Center on Institutions and Alternatives, Washington, D.C., 1981.[11]

National Commission of Correctional Health Care

Finally, in January 1987, the National Commission of Correctional Health Care (NCCHC) published a substantially revised version of the AMA's *Standards for Health Services in Jails* (1981). The NCCHC *Standards* offer the most comprehensive suicide prevention standards to date:

J-58. Suicide Prevention (essential)

The jail has a written plan for identifying and responding to suicidal individuals.

(Continued on Page 6)

STATE STANDARDS AND SUICIDE PREVENTION: A REPORT CARD

In response to mounting criticism of conditions within local jails, most states adopted jail standards in the late 1960's. The call for standards came not only from reform and professional groups, but from the financial and technical encouragement of the federal government. Through the U.S. Justice Department's Law Enforcement Assistance Administration (LEAA), the development, promulgation and enforcement of standards represented a significant part of a state's responsibility for maintaining and improving the conditions of local jails. However, according to a 1984 report by the Advisory Commission on Intergovernmental Relations, "...states still have a distance to travel to fulfill their standards/enforcement responsibility. A substantial number either have not established standards or have made them only voluntary. Many states do not have inspection programs, and even in those that do, the effectiveness of enforcement frequently is not assured."[1] Yet, most experts agree that state jail standards/inspection programs have made progress, however modest.

Staff of the *Jail Suicide Update* recently surveyed all 50 states in an effort to determine the general extent of jail standards within those jurisdictions, as well as to critique the degree in which state standards reflect aspects of suicide prevention. Results of our survey, as detailed on page five, showed that only 36 of the 50 states currently have either voluntary or mandatory jail standards. Five states (Alaska, Connecticut, Delaware, Hawaii and Rhode Island) operate an integrated jail and prison system and, therefore, have either not promulgated jail standards or claim to follow ACA Standards. (The state of Vermont, however, utilizes standards for its local holding facilities while operating an integrated jail and prison system.) The remaining nine states — Colorado, Georgia, Mississippi, Missouri, Montana, Nevada, New Mexico, South Dakota, and Wyoming — have no standards for detention and holding facilities.

As can be seen in our report card on the following page, most jail standards utilized by states lack even the basic criteria for suicide prevention. We scored the standards according to whether they ***specifically*** identified four areas — intake screening (indicating suicidal behavior inquiry), suicide prevention policies and procedures, staff training in suicide prevention, and supervision levels for potentially suicidal inmates. Survey results indicated that ***only eight (8) state jail standards specify suicidal behavior inquiry in their intake screening,*** the remaining standards utilize intake screening criteria reflective of earlier versions (1977-1978) of the American Medical Association's screening forms.

Less than one-third (11 of 36) of all state jail standards have specific policies and procedures regarding suicide prevention. Only three states — California, Washington and West Virginia — call for a written suicide prevention program, as recommended in the American Correctional Association standards (see page 2 of this *Update).* Although voluntary, jail standards in Washington specify that "programs for the prevention of suicide, to include early identification of risk, appropriate diagnosis and referral, and close observation...should be developed by medical staff."[2] In addition, ***only six (6) standards specify suicide prevention training in their staff training curriculum.***

Finally, despite the 30 minute observation requirement for general population inmates contained in most national correctional standards, 19 standards call for supervision checks of 60 minutes or more, and 12 standards do not specify a time frame. Only five (5) standards require 30 minute checks of general population inmates. In regard to observation levels afforded suicidal inmates, eight (8) standards call for only 30 minute checks, three (3) standards at 15 to 20 minute intervals, and 12 standards do not specify a time frame. An additional 11 standards are ambiguous regarding observation, with checks ranging from "close" or "frequent" observation to "consistent with behavior." ***Only two states — New York and West Virginia — specify "continuous" observation for certain groups of suicidal inmates.***

Four states — Iowa, Maine, South Carolina and West Virginia —provide examples of standards reflecting comprehensive suicide prevention programs. Jail standards in each of these states specify suicide prevention policies for screening, training, supervision, emergencies, restraints, and classification. South Carolina, for example, specifies inclusive (jail management, operations, pre-service and in-service) training in suicide prevention, while West Virginia standards detail a suicide watch — "Inmates who are classified as potential suicide risks shall be continually monitored including verbal exchanges. Recording of this monitoring shall be made and placed in the inmate's health record. High risk persons shall be placed on continuous suicide watch."[3] Iowa requires that incident reports of suicides and suicide attempts be kept in a separate injury file within the facility for a period of five years.

Overall, ***the report card from the states shows failing grades for suicide prevention.*** With a few notable exceptions, most state standards have failed to follow the suicide prevention guidelines as promulgated from such nationally-recognized organizations as the American Correctional Association, American Medical Association and the National Commission of Correctional Health Care.

Footnotes

[1]Advisory Commission on Intergovernmental Relations, *Jails: Intergovernmental Dimensions of a Local Problem.* Washington, D.C.: May 1984, p. 103.

[2]State of Washington, *Custodial Care Standards for Detention Facilities,* 1987 (revised), p. 57.

[3]State of West Virginia, *West Virginia Minimum Standards for Construction, Operation, and Maintenance of Jails,* 1988, pp. 16-17.

SUICIDE PREVENTION STANDARDS BY STATE

State	Facility Applicability		Intake Screening (Including Suicidal Behavior Inquiry)	Suicide Prevention Procedures	Suicide Prevention Staff Training	Minimum Supervision Levels	Most Recent Revision in Standards
	Detention	Holding					
Alabama	X					General: 90-240 minutes Suicide: Not specified	1982
Arizona	X	X				General: 60 minutes Suicide: 30 minutes	1981 (Proposed)
Arkansas	X	X				General: 60 minutes Suicide: 30 minutes	1987
California	X	X		Written Program	X	General: Not specified Suicide: 30 minutes	1988
Florida	X	X		X		General: Not specified Suicide: 15 minutes	1988
Idaho	X	X				Not specified	1985
Illinois	X					General: 30 minutes Suicide: Less than 30 minutes	1988
Indiana	X					General: 60 minutes Suicide: "Consistent with Behavior"	1981
Iowa	X	X	X	X	X	General: 60 minutes Suicide: 30 minutes	1988
Kansas	X	X		X		General: 60 minutes Suicide: 30 minutes	1985
Kentucky	X	X				General: 60 minutes Suicide: 20 minutes	1986
Louisiana	X	X				Not specified	1980
Maine	X	X	X	X	X	General: 30 min (detention); 15 min (holding); Suicide: "Closer Observation"	1982
Maryland	X		X			General: Not specified Suicide: 30 minutes	1985
Massachusetts	X	X				Not specified	1987-1988
Michigan	X					General: 60 minutes Suicide: "Close Supervision"	1975
Minnesota	X	X		X		Not specified	1983
Nebraska	X	X				General: 60 minutes Suicide: Not specified	1987
N. Hampshire	X					General: 60 minutes Suicide: "Frequent Observation"	1982
New Jersey	X	X				Not specified	1979
New York	X	X	X	X		General: 30 minutes; Active: 15 minutes; Constant: Continous	1987
North Carolina	X	X				Not specified	1981
North Dakota	X	X				General: 60 minutes Suicide: "More Frequent Intervals"	1981
Ohio	X	X	Detention facility only	X	Detention facility only	General: 60 minutes Suicide: 15-20 minutes	1986
Oklahoma	X	X	Detention facility only			General: 60 minutes Suicide: "Observe Frequently"	1986
Oregon	X	X				General: 60 minutes Suicide: Not specified	1987
Pennsylvania	X					Not specified	1984
South Carolina	X	X	X	X	X	General: Not specified Suicide: "Short, Irregular Intervals"	1985
Tennessee	X	X				General: 60 minutes Suicide: "More Frequent"	1988
Texas	X	X				General: 60 minutes Suicide: "More Frequent"	1984
Utah	X	X				General: 120 minutes Suicide: Not specified	1984
Vermont		X				General: 60 minutes Suicide: 30 minutes	1985
Virginia	X	X				General: 60 minutes Suicide: Not specified	1988
Washington	X			Written Program		General: 60 minutes Suicide: "Closely Supervised"	1987
West Virginia	X	X	X	Written Program	X	General: 30 minutes Suicide: Continous to 15 minutes	1988
Wisconsin	X	X				General: Not specified Suicide: "Close Watch"	1983

NATIONAL STANDARDS OF JAIL SUICIDE PREVENTION

(Continued from page 3)

Discussion. While inmates may become suicidal at any point during their stay, high-risk periods include the time immediately upon admission to a facility; after adjudication, when the inmate is returned to a facility from court; following the receipt of bad news regarding self or family (such as serious illness or the loss of a loved one); and after suffering some type of humiliation or rejection. Individuals who are in the early stages of recovery from severe depression may be at risk as well. The facility's plan for suicide prevention should include the following elements.

a. Identification. The receiving screening form should contain observation and interview items related to the inmate's potential suicide risk.

b. Training. All staff members who work with inmates should be trained to recognize verbal and behavioral cues that indicate potential suicide.

c. Assessment. This should be conducted by a qualified mental health professional, who designates the inmate's level of suicide risk.

d. Monitoring. The plan should specify the facility's procedures for monitoring an inmate who has been identified as potentially suicidal. Regular, documented supervision should be maintained.

e. Housing. A suicidal inmate should not be placed in isolation unless constant supervision can be maintained. If a sufficiently large staff is not available that constant supervision can be provided when needed, the inmates ***should not be isolated.*** Rather, s/he should be housed with another resident or in a dormitory and checked every 10-15 minutes. The room should be as nearly suicide-proof as possible (that is, without protrusions of any kind that would enable the inmate to hang him/herself).

f. Referral. The plan should specify the procedures for referring potentially suicidal inmates and attempted suicides to mental health care providers or facilities.

g. Communication. Procedures for communication between health care and correctional personnel regarding the status of the inmate should exist, to provide clear and current information.

h. Intervention. The plan should address how to handle a suicide in progress, including how to cut down a hanging victim and other first-aid measures.

i. Notification. Procedures for notifying jail administrators, outside authorities, and family members of potential, attempted, or completed suicides should be in place.

j. Reporting. Procedures for documenting the identification and monitoring of potential or attempted suicides should be detailed, as should procedures for reporting a completed suicide.

k. Review. The plan should specify the procedures for medical and administrative review if a suicide does occur.[12]

Conclusion

The evaluation of national correctional standards relating to suicide prevention has progressed significantly in recent years. Many national organizations and other influential bodies have recognized that, because suicide remains the leading cause of death in jails, standards need to be promulgated and revised to address the specific area of suicide prevention. Once a footnote in medical care standards, suicide prevention is now addressed separately and distinctly in most national standards. Although not yet gaining full prominence, national standards for suicide prevention have provided the opportunity and framework for local jurisdictions to create and build upon their policies and procedures for the prevention of jail suicides.

Footnotes

[1]U.S. Department of Justice, National Institute of Justice, *American Prisons and Jails,* Volume 1, October 1980, p. 33.

[2]Ibid, p. 39.

[3]Lonergan, Thomas F. *Minimum Standards,* AELE Seminar, No Date.

[4]American Correctional Association, *Standards for Adult ocal Detention Facilities,* College Park, Maryland, 1981, pp. vii.

[5]American Medical Association, *Standards for Health Services in Jails,* Chicago, Illinois, 1979, p. iii.

[6]Ibid, 1981 Edition, p. 23.

[7]American Correctional Association, *Standards for Adult Local Detention Facilities,* College Park, Maryland, 1981, pp. 47 and 72.

[8]American Correctional Association, *Correctional Standards Supplement,* 1988, p. 63.

[9]Ibid, p. 67.

[10]Commission on Accreditation for Law Enforcement Agencies, *Standards for Law Enforcement Agencies,* Fairfax, Virginia, 1983, p. 72-3 and 72-6.

[11]American Public Health Association, *Standards for Health Services in Correctional Institutions,* Washington, D.C., 1986, p. 39.

[12]National Commission of Correctional Health Care, *Standards for Health Services in Jails,* Chicago, Illinois, 1987, pp. 37-38.

PRISON SUICIDES IN MARYLAND

According to a study published in the July 21 issue of the *Journal of the American Medical Association,* the suicide rate among inmates in the Maryland prison system is nearly twice the rate of the state's general population. The study — *Suicide Mortality in the Maryland State Prison System, 1979 through 1987* — was authored by Marcel E. Salive, Gordon S. Smith and Fordham Brewer.

The researchers identified 206 inmate deaths as occurring in the state prison system over a nine year time period. Thirty-seven (17.7%) were classified as suicides, 2 undetermined, 17 drug-related, 9 accidental, and 141 natural deaths. Based upon these 37 suicides, the researchers calculated that there were 39.6 suicides per 100,000 prison inmates, compared with general population within Maryland of 22 per 100,000.

The researchers estimated that suicide ranked second to heart disease (48 per 100,000) in terms of death rate, but first in terms of years of potential life lost before age 65, reflecting the fact that suicide rates were higher in younger male inmates.

The study found a higher suicide rate for White inmates, as well as those aged 25 to 34, committing personal offenses, and housed in a maximum security institution. Although the length of actual time served by inmates who committed suicide varied widely, only 22 percent of the inmates who committed suicide had sentence lengths under eight years. Hanging was the method of suicide in 86 percent of the cases, followed by cutting (5%), anti-depressant overdose (5%) and falling from height (4%).

Despite being hampered by a small sample size and the awkwardness of transposing the findings to the jail environment, the present study offers fresh data and insight to the research-barren field of prison suicide. Study recommendations include: suicide risk assessment for all incoming inmates, early intervention for mentally disturbed inmates, utilization of mental health staff at the intake process, maintaining an increased level of awareness of suicidal behavior in inmates during all health care encounters, and preventive interventions for long-term inmates.

The authors conclude: "That suicide is the leading cause of lost years of potential life in the prison system suggests that correctional health care personnel must maintain a high index of suspicion for suicide risk among inmates, since it represents potentially the most preventable cause of death in prisons."

To obtain a copy of the study, contact Marcel E. Salive, M.D., National Center for Health Services Research, 5600 Fishers Lane, Room 18A19, Rockville, Maryland 20857.

JAIL SUICIDE UPDATE

This technical update, published quarterly, is part of the National Center on Institutions and Alternatives (NCIA)'s continuing effort to keep state and local officials, individual correctional staff and interested others aware of developments in the field of jail suicide prevention. Please contact us if you are not on our mailing list, or desire additional copies of this publication. As NCIA also acts as a clearinghouse for jail suicide prevention information, readers are encouraged to forward pertinent materials for inclusion into future issues.

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AVAILABLE JAIL SUICIDE PREVENTION MATERIALS

And Darkness Closes In. . .National Study of Jail Suicides (1981)

National Study of Jail Suicides: Seven Years Later (1988)

Training Curriculum on Suicide Detection and Prevention in Jails and Lockups (1988)

Curriculum Transparencies (1988)

Jail Suicide Update (Volume 1)

*For more information regarding the availability and cost of the above publications, contact **either:***

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NIC Information Center
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Boulder, Colorado 80301
(303) 939-8877

-airbanks inmate :hoelace to hang

:y BARBARA ROGERS
Times Writer

A Fairbanks Correctional Center inmate apparently hanged himself with a shoelace Tuesday evening a short time after he was booked into the facility on a variety of misdemeanor charges.

... Henson ... Point

ately, Brown s... nary investigati... said resuscita... tempted, and em... nel were notified

Alaska State T... banks are resp... ducting the over... a spokesman sa... gation was incor... ing.

The man, br... rectional center... Police Departm... harged with sh... gree assault a... ss at the Coo... cond Ave., ... man said.

Brown said ... and out of ...

Judgement call left jail suicide victim with his belt

By ROBERT TANNER
Democrat Staff Writer

SEABROOK — The Hampton man who committed suicide in a Seabrook jail cell July 7 was imprisoned with the belt with which he hanged himself, a violation of standard proce... dure but not law, Ro... ty Attorney Carleto... Friday.

"It's standard ope... when you put peopl... move potentially h... clothing). That ope... was not ignored or ... a judgement call b... cumstances," said ... has asked state poli...

'y police failed :heck prisoner hanged himself

SLER
Call

...e failed to look in ...hol counselor who ...nday night in the ... Chief Wayne T. ...erday.

...ducting an internal ...etermine who was

Records show police checked on Gunn at 5:23 p.m. and 5:57 p.m. But he was not checked again until officers found him hanging in the cell at 7:05 p.m., Stephens said.

He had been dead about one hour when he was found, Snyder said.

Gunn, who had been fighting with his live-in girlfriend for the second time Sunday night when police ar-

Hanging raises questions

Cell not checked for 15-30 minute

By Edwin Garcia
The Stockton Record

The 28-year-old San Joaquin Cou... ail inmate who died after hanging h... elf in his cell Tuesday may have be... anging for up to 30 minutes before ... il staff found him, authorities said.

Coroner's Capt. Baxter Dunn of ...an Joaquin County Sheriff's office s... he inmate, Kevin Randall Calvert ...alt, "had been hanging anywhere ...ween 15 to 30 minutes."

Capt. Richard Sealy, in charge of ... il complex, acknowledged that me... obody walked by Calvert's cell for ...east 15 minutes.

"Based on the design of the facil... nd size of the staff, that's basically h... "We do

County faces a lawsuit in hanging death

The family of a man who committed suicide in the Alpena County Jail last year has filed suit in federal court charging Alpena County with negligence and other offenses in the death.

The suit, filed June 27 in U.S. District Court in Bay City, seeks a $10 million award fo... the estate of Joseph Garcia, 27, of Monroe, Mich.

Garcia was found hanged to death June 20, 1988, in his cell. He was being held on $50,000 bond while authorities prepared a criminal case against him for alleged delivery of cocaine.

The plaintiff in the suit is Thom...

Jail suicide suit to be settled

By Rob Huesca
Dispatch NeighborNews Reporter

Hilliard Law Director Charles Schneider has been authorized to settle a wrongful death lawsuit out of court with the family of a man who committed suicide in the city jail two years ago.

In a secret session Monday, the City Council informally approved the settlement with the family of Robert Humble, Schneider said.

"Until all the papers are signed and everything is over and done with, I'd prefer not to disclose the amount," he said.

Humble hanged himself with his belt in a jail cell after being arrested Aug. 15, 1987, on charges of disorderly conduct and intoxication. The family filed a $23 million lawsuit a year later.

The settlement is expected to be completed within two weeks, said attorney Robert Berry, who represented Hilliard. The amount will be paid by the city's insurance company.

After the suicide, jailing policy in Hilliard was reviewed by an outside consultant. Modifications included:

- The installation of a video camera for each of the jail's two cells.
- The installation of clear, rigid plastic sheeting over the top tier of the bars to prevent prisoners from hanging blankets, sheets or other objects over them.
- Changing the maximum holding time to eight hou... from five days.

An internal review found that an officer on the day of the hanging had been negligent in monitoring the prisoner, Police Chief Rodney Garnett said.

Officials' awareness raised after string of suicides in jails

By AL ROGERS
Daily Journal

From the investigator's office at the Lee County Sheriff's Department, where most prisoners are booked, fingerprinted and photographed, it is only a few short steps down a dimly lit corridor into the southwest cell block.

Amid muffled voices that echo

Lawsuit resolved—

Suicide victim's wife, child are awarded settlement

(Editor's note: The following story is reprinted from the July 19 issue of *The Salina Journal*.)

A lawsuit filed by the Salina widow and child of a man who hanged himself in the Marion County Jail in 1987 was settled Tuesday for an undisclosed amount.

The settlement was approved by Saline County District Court Judge David Knudson on behalf of Rhonda Lee and her two-year-old daughter, Jessica Monarez.

Lee was married to Antonio Reyes Monarez, who died Jan. 7, 1987.

The suit was filed against former Marion County Sheriff Mike Childs and the Marion County Commission. Also listed as defendants were employees of the sheriff's office at the ... Deputy ... art ... H...

to shoot him, officials said. Childs suffered broken legs.

Monarez was jailed in McPherson until Jan. 7, 1987, when Huntley and Bartlett placed Monarez in a Marion County cell by himself.

At 7:27 p.m., Monarez was found hanging in the cell.

... the county and

Jail sergeant says he was unaware of inmate's threat

Five jail suicides recently

By AL ROGERS
Daily Journal

In the past four months, five Northeast Mississippians have hanged themselves while they were being held in jail cells in Corinth and Tupelo and Monroe and Pontotoc counties.