Montana Legislative Services Division

Legal Services Office

PO BOX 201706
Helena, MT 59620-1706
(406) 444-3064
FAX (406) 444-3036

TO: Law and Justice Interim Committee

FROM: David S. Niss, Staff Attorney

RE: No. 1 - Custer County Jail Suicide Case Study and Analysis

DATE: June 13, 2008

I
INTRODUCTION

As determined by a Custer County coroner's jury in January of this year,[1] Ms. Linda L. Wilson committed suicide in the Custer County Jail on November 5, 2007, by hanging herself from a telephone cord in the top tier of cells at the county jail in Miles City, Montana. On April 28, 2008, her husband and daughter, through their attorney, filed a wrongful death civil suit against Custer County, Miles City, the Custer County Sheriff and two named Custer County employees, and an employee of the Miles City police department for negligence in the wrongful death of his wife and her mother. The suit seeks unspecified monetary damages.

Because the civil action in Custer County District Court bears directly upon a county's constitutional obligation to use a working suicide prevention program as part of the operation of a lawful detention facility,[2] this case study has been prepared for use by the Law and Justice Interim Committee (LJIC), which voted at its February meeting to study suicide prevention in local jails. All of the facts of a testimonial nature referred to in this Memorandum are taken from the transcript of the coroner's inquest, Coroner's Inquest No. DC-9-2007-1000, January 28, 2008, on file in staff offices. References are also made to allegations contained in the complaint in the lawsuit, Kelly v. Custer County, Cause No. DV-08-55, also on file in staff offices.

[1]Section 46-4-201(2)(a), MCA, requires an inquest whenever a prisoner dies in a jail.

[2]The Committee staff memorandum dated September 14, 2007, to the Committee listed a "basic program of identification, treatment, and supervision of prisoners with suicidal tendencies" as one of the constitutionally required six "well-known criteria for a constitutional mental health care system" in state prisons and jails, as required in cases such as Ruiz v. Estelle, 503 F. Supp. 1265 (S.D. Tex. 1980).

II
DISCUSSION

a. Testimony and allegations

Linda Wilson, having previously been sentenced for felony DUI (fifth offense), was picked up by her probation officer on November 5, 2007, for violating a condition of her probation, that she not drink alcohol, and was brought to the Custer County Jail by her probation officer at approximately 3:00 p.m.[3] When the probation officer arrived at the county jail with Linda, the probation officer told Custer County Detention Officer No. 1[4] that she, Linda Wilson, should be put under a suicide watch (the civil complaint alleges that Linda had told her parole officer several times "she (Linda) would kill herself before going back to jail"[5]).[6] That statement by the probation officer was also relayed, somewhat later, to Custer County Detention Officer No. 2.[7] Linda was "booked" into the jail and taken to the top tier of cells in the jail by Detention Officer No. 1 at approximately 3:20 p.m. on November 5.[8] At the time she was booked into the Custer County Jail, Linda's breath alcohol content was 0.15.[9] A telephone with a metal-wrapped cord was outside her cell, but access to the telephone was allowed because the door to her individual cell was left open.[10]

Fifty minutes later, at approximately 4:20 p.m., Detention Office No. 2 took a food tray up to Linda.[11] Linda knew Detention Officer No. 2. Detention Officer No. 2 testified that Linda said that she hated to be in the jail, that she acted nervously, and that she said,

---

[3]Transcript of Coroner's Inquest No. DC-9-2007-1000, January 28, 2008 (hereinafter "Transcript"), pp. 6, 12, 19, 20, 21; Kelly v. Custer County, Cause No. DV-08-55, Complaint (hereafter "Complaint"), page 4.

[4]The names of the Custer County detention officers appear in the transcript of the coroner's inquest but have not been used in this memo.

[5]Complaint, p. 5.

[6]Transcript, pp. 12, 21.

[7]*Id*, p. 21.

[8]*Id*., pp. 19, 20, 21.

[9]*Id*., p. 44.

[10]*Id*., pp. 22, 34, 35.

[11]*Id*., p. 20.

pacing the cell, that she "really screwed up this time".[12] Detention Officer No. 2 stayed for 10 or 15 minutes and left, saying that he would come talk to Linda after the food trays were distributed to other inmates.[13]

Detention Officer No. 2 testified that by the time food trays were being prepared, Detention Officer No. 1 had "put up" a suicide watch on Linda (the civil complaint alleges that Detention Officer No. 1 put Linda on "suicide watch" at 3:45 p.m.[14]).[15] When asked to explain the suicide watch at the coroner's inquest, Detention Officer No. 2 testified: "suicide watch -- we just keep a closer watch on them. Usually kind of have somebody try to watch the cameras and check every 10 to 15 minutes, supposedly, if we can, but sometimes it gets hard to do."[16]

When the two detention officers were preparing the meals for all of the prisoners, they discussed what belongings to take from Linda and discussed the fact that taking belongings because of a suicide watch sometimes "makes them [inmates] worse".[17] The two officers decided to leave her clothes, blanket, and bed sheet with Linda but to take "little things".[18]

At approximately 5:05 p.m., Linda used the intercom in her cell to call the dispatcher in the jail and asked to see a detention officer.[19] The dispatch officer testified at the inquest that there was nothing in Linda's tone of voice when she made the call on her intercom that indicated an emergency.[20] Detention Officer No. 2 testified that because the officers were all engaged in their other duties, he did not respond to Linda's intercom request until between 5:17 and 5:22 p.m. (estimated)[21]

---

[12]*Id.*, p. 24.

[13]*Id.*, p. 20.

[14]Complaint, p. 5.

[15]Transcript, p. 21.

[16]*Id.*, p. 21.

[17]*Id.*, p. 24.

[18]*Id.*, p. 24.

[19]*Id.*, p. 13.

[20]*Id.*, p. 13.

[21]*Id.*, pp. 7, 13, 25.

When Detention Officer No. 2 arrived at Linda's cell between 5:17 and 5:30 p.m. (estimated), Linda was outside her cell, in a kneeling position, with the metal-covered telephone cord wrapped around her neck.[22] He then radioed Detention Officer No. 1 through the dispatcher (the complaint alleges at 5:30:41 p.m.) to come to Linda's cell immediately, and when Detention Officer No. 1 arrived, they both lifted Linda out of the phone cord and began CPR.[23] An ambulance was called, but attempts to revive Linda were unsuccessful.[24]

b. Potential basis for liability

According to Cohen,[25] the cases finding liability for suicides while individuals are in custody break down into the following categories of causes for the death:

1. Failure to properly screen for suicide potential;
2. Failure to convey information relevant to suicide potential;
3. Failure to recognize signs and symptoms of suicide;
4. Failure to provide a safe environment;
5. Failure to train detention personnel;
6. Failure to act promptly or properly after an act of suicide;
7. Failure to search or remove implements or material suitable for suicide;
8. Design failure;
9. Failure to provide appropriate treatment.

An analysis of the known and alleged facts of Linda Wilson's suicide may demonstrate which of these categories, if any, Linda Wilson's suicide falls into and therefore might help clarify the basis for liability.[26]

c. Analysis of testimony and allegations

---

[22]*Id.*, p. 26.

[23]*Id.*, pp. 27, 28.

[24]*Id.*, p. 28.

[25]Fred Cohen, The Mentally Disordered Inmate and the Law, Civic Research Institute, Inc., 1998, page 14-4.

[26]No attempt is made here to definitively catagorize any failures at the Custer County Jail into one of Cohen's categories or another. Cohen's categories are only used to demonstrate that one set of facts may establish liability based on more than one theory of failure of the jail personnel or jail administration in the jail's constitutional obligation to the prisoner.

While other facts may come out at trial if the case is tried and while it's difficult to predict the outcome of litigation that's just begun, the following facts taken from the inquest transcript and the allegations in the complaint are very significant:

1. Detention Officers No. 1 and 2 knew Linda was thought to be suicidal by another law enforcement officer (case law refers to this type of knowledge as "actual knowledge", which plays a large part in suicide litigation because it is from this knowledge that a duty of care for the prisoner arises).

2. Linda was put into an unmonitored, nonobservation cell.

3. The door to Linda's cell was left open, giving her access to a telephone cord long enough for Linda to hang herself.

4. Linda was left physically unobserved for two different periods of time, approximately 50 minutes the first time (between when she was booked and before her meal was served to her by Detention Officer No. 2) and from 47 to 60 minutes the second time (after her meal was served to her by Detention Officer No. 2).

5. Linda was left alone during these two time periods contrary to Custer County written detention policy 4-04-02.1 that, as alleged in the complaint, requires all prisoners to be checked on at least every 30 minutes.[27]

6. Linda was left alone for these two time periods, despite a 0.15 breathalyzer test, contrary to the Montana Detention/Jail Standards (2006) 07.01, providing for more frequent observation than once every 30 minutes for intoxicated persons in county jails.

7. Custer County adopted written detention policy 4-04-02.1, as alleged in the complaint, requiring all prisoners to be checked on every 30 minutes, contrary to the Montana Detention/Jail Standards (2006) 07.01, providing for more frequent observation than once every 30 minutes for intoxicated persons in county jails.

8. A suicide watch was put up on Linda when Linda was booked into the jail, as testified to by Detention Officer No. 2 (the complaint alleges on page 5 that the suicide watch was put up at approximately 3:45 p.m).

9. Linda was left alone for these two time periods in violation of Custer County written detention policy 4-04-02.2 that requires, as alleged in the complaint, a prisoner under a suicide watch to be checked on every 15 minutes.

10. Linda was left alone for these two time periods contrary to the Montana Detention/Jail Standards (2006) 08.04, providing for "continuous observation" of a suicidal inmate until the inmate is seen by a mental health professional.

11. Custer County adopted written detention policy 4-04-02.2, as alleged in the complaint, requiring suicidal prisoners to be checked on every 15 minutes, contrary to the Montana Detention/Jail Standards (2006) 08.04, providing for "continuous observation" of a suicidal inmate until the inmate is seen by a mental health professional.

---

[27]All references to Custer County detention policies in this memorandum are references to those policies as "alleged" by the plaintiff in Kelly v. Custer County, Cause No. DV-08-55, because this writer had not actually seen those Custer County written detention policies by the time this memorandum was prepared. See footnote 28.

At this time, except for allegations in the complaint in some cases, it's unknown whether the Custer County Jail has a "written suicide prevention and intervention program reviewed and approved by a qualified medical or mental health professional" and whether "all staff with responsibility for inmate supervision is trained in the implementation of the program" (Montana Detention/Jail Standards (2006) 04.01, 11.12); whether the Custer County suicide prevention policy addresses the issue of what to take from a suicidal prisoner and whether that policy was followed; whether the Custer County Jail has a written policy governing screening, referral, and care of suicide-prone inmates (Montana Detention/Jail Standards (2006) 11.04f, 11.35) and whether that policy was followed; whether the suicide prevention program policy was approved by the Custer County Jail's medical officer (Montana Detention/Jail Standards (2006) 11.04); whether a written or electronic screening instrument was used to screen Linda for mental health/suicide issues (Montana Detention/Jail Standards (2006) 11.04f, 11.10e, 11.35); whether Detention Officer No. 1 who screened Linda was properly trained in the use of the screening instrument (Montana Detention/Jail Standards (2006) 11.10, 11.35); and whether Linda was immediately referred to health care services (Montana Detention/Jail Standards (2006) 11.10c, 11.35).[28]

d. Jail suicide case law factual patterns and rulings

Litigation arising from jail suicides has established the standard that a governmental entity and, in some cases, individual detention officers may be held liable for damages resulting from the suicide of an arrestee who was known by one or more detention officers to be a suicide risk if the officer does nothing to ensure the safety of the arrestee. Cases also exist finding liability in factual situations nearly identical to the facts in the case of Linda Wilson. For example, Simmons v. Philadelphia, 728 F. Supp. 352 (1990), involved the case of a 24-year-old man arrested for public intoxication. He was booked into a nonobservation cell in the city jail while he was "very intoxicated",

---

[28]Committee staff did request all of the written Custer County detention policies and other documents from the Custer County Attorney to help verify the allegations in the complaint, but the Custer County Attorney declined to provide them. The e-mail dated May 27, 2007, from the Custer County Attorney is clear that the reason the requests for the documents were denied by the County Attorney is because of the litigation in Kelly v. Custer County, Cause No. DV-08-55. However, the status of the requested documents as public or private documents, including the Custer County written detention policies, is not an issue in Kelly. Additionally, Art. II, sec. 9, of the Montana Constitution (Right to Know) applies to the public's right to both view public meetings and view public documents. The Montana Supreme Court held, in Assoc. Press v. Bd. of Pub. Educ., 246 M 386, 804 P2d 376, 48 St. Rep. 1 (1991), that an attempt by the Legislature to enact a statutory "litigation exception" was unconstitutional because Art. II, sec. 9, is clear and unambiguous in its application to both the state and political subdivisions of the state. The e-mail is available in staff offices.

was seen by the detention staff to be anxious over his arrest for a minor violation, and was not physically observed by a detention officer for over an hour, despite the fact that the jail had a standard that required physical or electronic observation every 15 minutes. The court held that the actions of the detention staff constituted "deliberate indifference" to the arrestee's serious medical needs (suicide prevention) based upon the testimony of two expert witnesses who testified that intoxicated arrestees should be continuously observed. In Danese v. Asman, 670 F. Supp. 709 (1987), involving the suicide by hanging of an inmate in a city jail, a federal court held that the defendants' actions of putting an inmate known to be suicidal, who scored a 0.13 breathalyzer test at booking, into a nonobservable jail cell constituted "deliberate indifference" to the serious medical needs (suicide prevention) of the suicide victim and also held that those same acts by the jail staff constituted gross negligence.

e. Suicide by telephone cord a well-known phenomenon

A compilation of jail suicides from around the country shows that suicide by telephone cord is a well-known phenomenon. A 2007 publication by the National Institute of Corrections of the U.S. Department of Justice[29] showed the following figures:

INMATE SUICIDES UTILIZING TELEPHONE CORDS

The following listing should not be considered comprehensive; it is simply a listing of inmate suicides utilizing telephone cords known to Lindsay M. Hayes[30] from 1990 to the present.

Arizona
Maricopa County Jail, July 1996
Pinal County Detention Center, July 2001
Scottsdale Police Department, September 2003

California
Alameda County Jail, March 2004
Alameda County Jail, October 2003
Alameda County Jail, January 1997
El Dorado County Jail, September 2005
Long Beach City Jail, July 1999
Los Angeles Courthouse Holding Unit, October 2004
San Diego County Jail, February 2000
Santa Clara County Jail, November 1988
Solano County Jail, June 2005
Solano County Jail, February 2004

New York
Rockland County Jail, April 1998

North Carolina
Orange County Jail, September 2003

Ohio
Cleveland Police Department, August 2008
Mansfield City Jail, January 2004
Mansfield City Jail, May 1999
Portsmouth City Jail, 1995

Oklahoma
Lincoln County Jail, February 2001
Pittsburg County Jail, September 2005
Pushmataha County Jail, December 2000

[29]Jail Suicide/Mental Health Update, National Institute of Corrections and its contractor, Volume 16, Number 2 (2007).

[30]Lindsay M. Hayes is the Project Director for the suicide prevention program at the National Center on Institutions and Alternatives, a contractor with the U.S. Department of Justice on jail and prison suicide issues and statistics.

Tulare County Jail (Bob Wiley Detention Facility), December 2005

Colorado
Jefferson County Jail, December 1990

Florida
Pinellas County Jail, January 2000
Volusia County Correctional Facility, October 1997

Georgia
Cobb County Jail, August 2002
Coweta County Jail, August 2005
Walton County Detention Center, April 2005

lowa
Marion County Jail, July 2005

Illinois
Coles County Jail, June 2002
Morgan County Detention Center, March 2007
St. Clair County Jail, February 2000
Will County Jail, November 2001
Hurst Police Department, April 1998

Kansas
Barton County Jail, April 2002
Sedgwick County Detention Facility, April 1994

Kentucky
Boone County Jail, October 2005
Fayette County Jail, June 2004

Louisiana
Rapides Parish Jail, June 2004
St. Tammany Parish Jail, May 2007

Michigan
Berrien County Jail, August 2000
Macomb County Jail, June 2001

Mississippi
Clinton Police Department, December 2000

Missouri
Christian County Jail, August 2000
Independence Police Department, February 2004
St. Clair County Jail, February 2000
Stephens County Jail, January 2001

South Carolina
Greenville County Jail, June 2004

Tennessee
Davidson County Jail, November 2005
Hawkins County Jail, August 2004

Texas
Allen Police Department, May 2000
Bandera County Jail, July 1998
Bee County Jail, February 1992
Benbrook Police Department, May 2003
Chambers County Jail, October 2003
Cockrell Hill Police Department, March 2000
Dallas County Jail, December 2002
Dallas County Jail, October 2000
Hardeman County Jail, June 1995
Harrison County Jail, February 1999
Johnson County Jail, May 2003
Katy Police Department, June 2001
McLennen County Jail, November 1998
New Boston Police Department, February 2000
Pasadena Police Department, October 2000
Port Isabel City Jail, December 1999
Port Isabel City Jail, November 1999
Seagoville Police Department, January 2000
Tarrant County Jail, January 1996
Van Zandt County Jail, May 2007

Virginia
Chesterfield County Jail, August 2007

Washington
King County Jail, October 1999
Thurston County Jail, January 2007

Wisconsin
Brown County Jail, June 2005

In Montana, at least one jail suicide victim prior to Linda Wilson used a telephone cord

to commit suicide.[31] That fact and the foregoing compilation provides adequate justification for legislative inquiry on this issue.

f. Montana liability statutes

Under 2-9-108, MCA, a county is not liable for negligence when operating a county jail unless the negligence of the officer, agent, or employee constitutes "gross negligence, willful or wanton misconduct, or an intentional act". A case such as Danese, supra, can be looked to for determining whether this statutory standard has been satisfied in the case of the suit against Custer County. Even if all of the facts, including those not revealed in the complaint or the transcript of the coroner's inquest, show that that standard has been satisfied, however, the state tort claims statutes impose monetary caps on tort judgments against a county[32] and require that the county be substituted as the defendant in any action against a county employee.[33] A county may also insure or self-insure for damages awarded because of the tortious conduct of its agents and employees.[34]

III
CONCLUSION

A civil action for damages has now been filed against Custer County, Miles City, the Custer County Sheriff, two named Custer County employees, and an employee of the Miles City Police Department alleging that the county and those employees at the county jail were negligent in failing to prevent the foreseeable suicide death of Linda Wilson. The foregoing recitation of facts shown at the coroner's inquest and allegations in the complaint and the foregoing citations to litigated suicide cases with facts nearly identical to those involved in Linda Wilson's case have been set forth in order to help the Committee determine whether counties are meeting their obligation to operate constitutionally sufficient jails and to demonstrate to the Committee those factors that might warrant legislative inquiry or action in order to reduce the incidents of inmate suicides in Montana's county jails.

Cl0429 8165dnba.

---

[31]Transcript, p. 41.

[32]Section 2-9-108, MCA. The dollar limitations in this section are $750,000 per claim and $1.5 million per each occurrence.

[33]Section 2-9-305, MCA.

[34]Section 2-9-211, MCA.

No. 1 - Custer County Case Study Executive Bullets

***** This document examines the known facts of Linda Wilson's suicide by hanging in the Custer County Jail on November 5, 2007, which has now resulted in a lawsuit against the County, Miles City, the Custer County Sheriff, and County and City employees. Testimony given at a coroner's inquest and allegations in the complaint are referred to in this analysis.

***** There is a strong indication that Custer County adopted a prisoner watch observation frequency policy with a required frequency of observation less frequent than the observation frequency standard for intoxicated persons in the voluntary Montana Jail/Detention Standards (2006). There is even stronger evidence that the County then failed to follow its own written policy.

***** There is a strong indication that Custer County adopted a suicide watch policy with a required frequency of observation less frequent than the voluntary Montana Jail/Detention Standards (2006). There is even stronger evidence that the County then failed to follow its own written observation frequency policy.

***** Based upon the transcript of the coroner's inquest, the allegations in the complaint, and case law involving jail suicides by intoxicated persons, the lawsuit could result in liability for damages against Custer County, Miles City, or both.

***** Suicide by telephone cord in a detention facility is a nationally recognized phenomenon, with at least one prior occurrence in Montana, and is a proper subject for legislative inquiry.