REPORT ON RECENT HIGH PROFILE INMATE SUICIDES WITHIN THE OHIO DEPARTMENT OF REHABILITATION AND CORRECTION: REVIEW AND LEGAL ANALYSIS

By: Lindsay M. Hayes, M.S.
&
Fred Cohen, LL.B., LL.M

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A. INTRODUCTION

The following is a summary of the observations, findings, and recommendations of Lindsay M. Hayes, M.S., and Fred Cohen, LL.B., LL.M. Mr. Hayes is a nationally-recognized expert in the area of suicide prevention within jails, prisons and juvenile facilities. He has been appointed as a court monitor, serves as an expert witness/consultant in inmate suicide litigation cases, and provides technical assistance consultation and training seminars to various state and local jurisdictions throughout the country, including the Ohio Department of Rehabilitation and Correction in both 1996 and 2004. Mr. Hayes has reviewed and/or examined over 3,500 cases of suicide in jail, prison, and juvenile facilities throughout the country during the past 33 years. Mr. Cohen is one of the foremost experts on correctional law and is generally recognized as the leading scholar and practitioner in correctional mental health law. He served as the court monitor in a settlement agreement regarding delivery of services to inmates with serious mental illness within the Ohio Department of Rehabilitation and Correction (*Dunn v. Voinovich*) and as independent consultant in a settlement agreement regarding the provision of medical and dental care to Ohio Department of Rehabilitation and Correction inmates (*Fussell v. Wilkinson*). He is the Executive Editor *of Correctional Law Reporter* and *Correctional Mental Health Report*, and the author of *Practical Guide to Correctional Mental Health and the Law*.

As of November 2013, the Ohio Department of Rehabilitation and Correction (DRC) experienced 10 inmate suicides during the calendar year, two of which received considerable notoriety. Pursuant to agency policy, each of the deaths received multiple layers of review, both internally and externally. In addition, DRC mental health officials have been reviewing various policy and procedural directives relating to suicide prevention. Because two of the recent deaths were of high notoriety, DRC Director Gary C. Mohr decided to seek the immediate assistance of outside consultants to independently assess all 2012 and 2013 inmate suicides and offer any appropriate recommendations regarding the two high-profile cases from a policy and legal perspective.[1]

The determination for the need of this additional independent assessment was not prompted by litigation or critical investigation of any of the recent inmate suicides. Rather, these actions were taken through the pro-active initiative of Director Mohr who was committed to determining what steps, if any, were necessary to improve suicide prevention practices within DRC.

Indeed, DRC previously commissioned an external review of mental health care as part of an internal Continuous Quality Improvement effort. A broader review of suicide-related policy and practices is expected to be an important part of that undertaking.

In conducting the assessment, we met with and/or interviewed numerous correctional, medical, and mental health officials and staff from the DRC; reviewed numerous policies and procedures related to suicide prevention, training curricula, and screening/assessment protocols; reviewed

[1]Two other suicides occurred on October 23, 2013 and November 17, 2013, and the appropriate health care and investigative files were not available for review prior to completion of this report.

various health care charts and investigative reviews of the 16 inmate suicides that occurred between January 2012 and August 2013; and toured both the Correctional Reception Center in Orient and the Chillicothe Correctional Institution in Chillicothe. The on-site assessments were conducted from October 8 thru October 11, 2013.

As of November 2013, the Ohio Department of Rehabilitation and Correction had an average daily population of 50,419 inmates, with over 20,000 admissions processed and assigned to 28 prison facilities each year. As shown by Table 1, the DRC has experienced 32 inmate suicides during the 5-year period of 2009 through 2013, including 10 deaths this year. Based upon the average daily population during this same time period, the suicide rate in the DRC was 12.7 deaths per 100,000 inmates — a rate that is lower than that of the national average of 14 deaths per 100,000 inmates found in other state prison systems throughout the country.[2] During 2013, however, the suicide rate within the DRC (i.e., 19.8 deaths per 100,000 inmates) is higher than the national average.

[2] According to Heron, M. (2012), "Deaths: Leading Cause for 2009," *National Vital Statistics Report*, 61 (7), Hyattsville, MD: National Center for Health Statistics, the suicide rate in the general population is approximately 12 deaths per 100,000 citizens. According to the most recent data on inmate suicide, the suicide rate in state prisons throughout the country is approximately 14 per 100,000 inmates, Noonan, M. and Ginder, S. (2013), *Mortality in Local Jails and State Prisons, 2000-2011 - Statistical Tables*, Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice, Office of Justice Programs.

TABLE 1
AVERAGE DAILY POPULATION, SUICIDES, AND SUICIDE RATE
WITHIN THE OHIO DEPARTMENT OF REHABILITATION AND CORRECTION
JANUARY 2009 THRU NOVEMBER 2013*

Year	ADP	Suicides	Suicide Rate
2009	51,060	4	7.8
2010	50,944	6	11.7
2011	50,627	4	7.9
2012	49,713	8	16.1
2013	50,419	10	19.8
2009-2013	252,763	32	12.7

*Source: Ohio Department of Rehabilitation and Correction

B. CASE REVIEWS

The consultant team reviewed all 16 inmate suicides that occurred in DRC facilities between January 2012 and August 2013. Summaries of two of those cases are provided as follows, with the remaining reviews provided to DRC during a secondary phase of this project and consistent with the agency's confidential Continuous Quality Improvement process.

Inmate Billy Slagle: The inmate, 44-years-old, committed suicide in the Chillicothe Correctional Institution (CCI) on August 4, 2013. Although his death occurred approximately 10 days after another suicide in the same facility, there was no indication that the two cases were related to each other. The present inmate had served more than 25 years of a death sentence for aggravated murder, robbery, and burglary, and had been scheduled for execution three days later on August 7, 2013. The inmate did not have a prior history of either suicidal behavior or mental illness, and was not on the mental health caseload. The inmate reportedly had strong family support, receiving regular visits and letter correspondence.

Although not on the mental health caseload, the inmate was seen on a regular basis by mental health staff (most recently cell-side on August 1, 2013) based upon his impending execution. The inmate was usually seen by the supervising psychologist at CCI. This clinician, as well as his progress notes, indicated that the inmate had limited interaction with mental health staff (often simply replying that he was "fine") and never requested mental health services during his confinement. During the month of July 2013, the inmate was seen by mental health staff at least weekly, including July 8, July 10, July 16, and July 24. In general, the progress notes documented that the inmate expressed no concerns and was not observed with any appreciable change in behavior. With regard to the July 16 and July 24 interactions, the supervising psychologist met with the inmate cell-side after he had received news that both the Parole Board and Governor's Office had rejected his requests for clemency. The clinician noted that although the inmate expressed disappointment and a subdued mood when receiving this news, these behaviors appeared as normal reactions from an inmate who was quickly approaching their execution date. Discussions with various correctional officers who worked on the unit also confirmed that the inmate did not exhibit any unusual behavior in the days and weeks prior to his suicide (and execution date).

The inmate was scheduled to be moved from his current "30-day watch cell" to a "72-hour watch cell" requiring constant observation that would begin at 6:00am on August 4. (Neither cell was suicide-resistant or utilized for suicidal inmates, and was simply identified for heightened visibility based upon location on the housing unit as the death row inmate approached their execution date.) In probable anticipation of such a cell relocation at 6:00am and increasing surveillance to constant observation, the inmate was found hanging from a belt tied to the conduit piping in his cell by an officer at approximately 5:06am on August 4. An emergency was called, correctional officers responded and initiated CPR until relieved by arriving medical personnel. (It appeared that outside emergency medical services (EMS) personnel were called by CCI medical staff approximately seven (7) minutes after notification of an emergency and CPR initiation.) The inmate was subsequently transported to a local hospital by EMS personnel and later pronounced dead.

An angry and extremely articulate suicide note from the inmate was found in his cell after the death suggesting that the death penalty had been arbitrarily applied in his case and indicating that he had decided to commit suicide because "I wasn't going to sit in a utterly hopeless situation and wait for the inevitable, so I've taken my destiny into my own hands. I found this whole process or ritual to be psychological, mental and emotional torture.... I also definitely wasn't going to sit and wait to be strapped to a gurney and have poison pumped into my veins so a bunch of strangers that have absolutely nothing to do with my case can surround me and be entertained by my execution."

A subsequent investigation into the death found that required observation of death row inmates at 30-minute intervals had not occurred during the shift and that a few officers falsified unit logs to indicate that the required cell checks were performed.

Summary: There were a few areas of concern in this case. In addition to the obvious problem of correctional staff failing to conduct required observation of death row inmates at 30-minute intervals as required, and then falsifying unit logs, proper visibility into the inmate's cell was obscured by poor lighting and the cell door configuration. In addition, correctional staff assigned to the death row housing unit had not received the required specialized mental health training, although such training was not relevant to the proximate cause of this suicide as there was no indication he was displaying any obvious signs of suicidal behavior. Further, although both correctional and medical personnel responded in a timely fashion to the medical emergency, a backboard (which was on facility grounds but not in the housing unit) was not utilized to transport the inmate down the stairs to the gurney. Rather, officers utilized a blanket to carry the inmate down to the gurney (thus impeding full immobilization of his head and neck area). Finally, it appeared that EMS personnel were untimely called approximately seven (7) minutes after notification of an emergency and CPR initiation.

Inmate Ariel Castro: The inmate, 53-years-old, committed suicide in the Correctional Reception Center (CRC) on September 3, 2013. He had served only just over one month of a life sentence without parole for multiple counts of aggravated murder, rape, kidnapping, child endangerment, felonious assault, and gross sexual imposition. The inmate had an unclear history of both suicidal behavior and mental illness. He was not on the mental health caseload at the time of his death. The inmate had been confined on a pre-trial detention basis at the Cuyahoga County Corrections Center (CCCC) in Cleveland, Ohio, from May 9, 2013 through August 2, 2013, when he was transferred to the Lorain Correctional Institution (LorCI). An "Inmate Transfer Medical Information Sheet" was completed by a CCCC nurse and forwarded to LorCI with the inmate indicating several medical issues, as well as a mental health diagnosis of Adjustment Disorder with Depressed Mood. The form also noted that he had a suicide attempt history and, although not on suicide precautions at the time of discharge from county custody, apparently had a history of suicide precautions in the facility. This information is limited to the nurse simply checking a box. The inmate subsequently denied any such attempt or present suicidal ideation.

Upon arrival at LorCI on August 2, the inmate was administered various intake screening forms, including the "Initial Medical/Mental Health/Substance Use Screening" form by a nurse and the "Detailed Mental Health Screening" (DMHS) form by a nursing supervisor. The results of each screening process were unremarkable, with the inmate denying any history of mental illness and suicidal behavior, as well as denying any current suicidal ideation. The mental status examination section of the DMHS form indicated that his affect was "blunted, appropriate for circumstances" and mood was "subdued." The nursing supervisor concluded that the "inmate will be placed on security constant watch/PC status in segregation until transfer. He believes he is depressed but has never been formally treated. Depression has only been since his arrest. States he was on suicide watch at county jail for the first week, D/T stating he was suicidal. Denies he actually was but just scared of GP and wanted to ensure he would be alone."

Following his placement on constant observation (thought to be at the direction of the LorCI Warden), the inmate was seen later in the evening of August 2 by a LorCI Psychology Supervisor. He reiterated a denial of both current and prior suicidal ideation or history and denied any history of mental illness, stating that he initially expressed suicidal ideation at the county jail only in order to be kept safely away from other inmates. The clinician noted that the "inmate seems fairly stable at the present time. He does not appear to be actively suicidal or self injury behavior inclined. There are a number of reasons that he cites as reasons to live including his religious beliefs, his family and his children. He has no prior mental health treatment history and there is no reported family history of suicide or salient mental illness.... He appears quite narcissistic, but does not show evidence of mood, anxiety or thought disorder.... Nevertheless, due to the security and safety risk of this inmate, he will be placed on Constant Suicide Watch more for practical than clinical reasons. In addition, due to his life sentence and a high-profile nature of his crimes he may pose some risk to his own safety and welfare especially as the gravity of the situation begins to sink in."

The inmate remained under constant observation in the LorCI from August 2 thru August 5 and was assessed on a daily basis by the psychology supervisor and continued "to show emotional stability and has not exhibited problematic or self-harm behavior" during that period. It was noteworthy that this clinician's progress notes were comprehensive and insightful.

On August 5, 2013, the inmate was transferred to the Correctional Reception Center (CRC). Pursuant to agency policy, the same intake screening forms, including the "Initial Medical/Mental Health/Substance Use Screening" and "Detailed Mental Health Screening" (DMHS) forms were again required to be completed. The intake screening form completed by nursing staff could not be located for review. The DMHS form completed by a CRC Psychology Supervisor was unremarkable and similar in content to the same form completed several days earlier at LorCI. The inmate again denied any history of mental illness and suicidal behavior, as well as denied any current suicidal ideation. The mental status examination section of the DMHS form indicated that his affect was "reactive, varied, no overt distress, depression" and mood was "irritated, then described as "happy." The psychology supervisor noted that, "based upon the nature of his crimes and lengthy sentence, a complete mental health evaluation will be completed." (A further mental health evaluation was not required per policy and the decision to conduct further testing was done pursuant to a directive from the CRC Warden.) As such, the clinician also completed both an extensive "Mental Status Examination" and "Mental Health Bio-Psychosocial Assessment." The evaluations described his initial mood as "upset," which the inmate "attributed to the constant verbal harassment reportedly directed towards him by other inmates in the segregation area since his placement there earlier today. As the interview progressed, he became more spontaneous, expressive, and reactive, smiling occasionally, in describing himself as 'always a happy person.' He explicitly denied that he was currently experiencing any significant depression, and his affect overall did not reflect dysphoria, overall distress, or anxiety."

The inmate's insight, however, was described by the clinician as "markedly impaired." For example, "his explanation for his criminal behavior focused on his 'sickness,' referring to his long-standing addiction to pornography, and the mutual culpability of his victims.... He presents as oblivious to the realities of his future situation, and is incredulous that the media and other inmates should treat him so poorly. His goals involve going to 'a quiet place and do my time in peace'." With regard to any risk for suicide, the clinician noted that, based upon the inmate's denial of any current or previous suicidal ideation or behavior, "he is considered to present a low risk for suicide at the present time. However, as situational factors change for him, particularly if they should challenge his sense of entitlement and fragile grandiosity, the level of risk may increase, suggesting the need for periodic assessment of his mental status." The clinician concluded his assessments with a diagnosis of "Narcissistic Personality Disorder with Antisocial Features," and recommended that "mental health should monitor periodically for any change in mental status or lethality risk, given his lengthy sentence, somewhat fragile self-esteem, and the notoriety of his crimes."

It is noteworthy that all of the assessments ("Detailed Mental Health Screening," "Mental Status Examination" and "Mental Health Bio-Psychosocial Assessment") conducted by this CRC Psychology Supervisor on this inmate were extremely comprehensive and insightful. In a subsequent interview with the consultant team, the clinician indicated that he had also seen the inmate several times on weekly segregation rounds in August and reiterated that the inmate was not displaying any unusual or concerning behavior other than complaining about the quality of food, lack of cleanliness of his cell, and requesting hygiene items. When questioned, however, the clinician also indicated that he had not reviewed the inmate's mental health chart from LorCI and, therefore, was unaware of other assessments and that the inmate was on suicide precautions at LorCI, nor was he aware of the discharge summary form forwarded from the Cuyahoga County Corrections Center.

The inmate was assigned directly to the segregation unit upon his arrival at CRC on August 5 and the required "Suicide Questionnaire and Medical Notification" form completed (as it had also been at LorCI), with the inmate again denying any current or prior suicidal ideation. He was placed in a far corner cell on the second floor of one of the segregation sections, out of direct visual observation from other inmates. Various inmates and correctional staff assigned to the segregation unit were interviewed by the consultant team. Not surprisingly, varying opinions were offered regarding the inmate. Several inmates indicated that correctional staff was constantly harassing the inmate by suggesting that his food had been tampered with. These inmates claimed that he had lost a significant amount of weight during his CRC confinement based upon a refusal to eat the meals.[3]

Due to the notoriety of the inmate's case, a special "Operations Order" was in effect that limited his movement in the segregation unit, prohibited any contact with other inmates and required a corrections supervisor to be present when the inmate was delivered meals

[3]The evidence indicated that the inmate lost 10 pounds during his approximate 30-day DRC confinement, i.e., weighing 178 lbs. on August 2 and 168 lbs. at his autopsy.

and removed from his cell. A corrections supervisor who was interviewed described the inmate as both "demanding and pompous," having to be redirected several times regarding facility rules (including wearing clothing when female correctional staff was making rounds of the unit). The supervisor indicated that neither inmates nor correctional staff was observed taunting and/or harassing the inmate. Records indicated that the inmate refused to leave his cell for recreation, and refused meals on several occasions. He had two family visits on August 12 and August 26 at CRC.

The inmate was interviewed by CRC's Protective Control Committee on the morning of his September 3 suicide. A member of the committee indicated to the consultant team that, although the inmate had not initially requested protective custody status, he told the committee that based upon "the high-profile nature of my charges, I believe I need protective control." He also appeared interested in being assigned to a prison facility that was in closer proximity to his family, and inquired about mail and visitation privileges. This individual indicated the inmate did not display any behavior suggestive of his impending death.

At approximately 9:18pm on September 3, 2013, an officer found the inmate hanging from a knotted bed sheet that was attached to the window frame in his cell. An emergency was called, other correctional officers responded and initiated CPR until relieved by arriving nursing staff. Records indicated that the call to EMS occurred at approximately 9:25pm and they arrived at the facility approximately 40 minutes later at 10:05pm. The inmate was subsequently transported to a local hospital and later pronounced dead.[4] A subsequent investigation determined that, although many of the required cell checks at 30-minute intervals were not performed as required during the shift (and several entries were falsified by correctional staff to indicate that the rounds were performed), the inmate was last observed at approximately 8:54pm — a period of approximately 26 minutes since the last round by staff.

[4] The correctional officer who discovered the inmate hanging wrote an incident report stating that upon arrival at the cell, he observed that the inmate's "shorts were around his ankles." A subsequent DRC review noted that "the relevance of this finding is unclear. These facts, however, were related to the Ohio State Highway Patrol for consideration of the possibility of auto-erotic asphyxiation." The fact that the inmate was a sex offender and self-proclaimed an addiction to pornography might lend to an initial suggestion that the incident was an accidental death. Yet, the simple mention of clothing around the inmate's ankles in one incident report should not be considered conclusory of anything. A subsequent review by the OSHP, as well as the Franklin County's Coroner's Office, determined that all available evidence indicated that the death was a suicide. In addition, in the consultant team's review of this case, one interviewed nurse indicated that the inmate was completely naked when she arrived at the scene, with a supervisor indicating it was not unusual for the inmate to be naked in his cell; whereas a few inmates who were interviewed (but had no visual observation of the inmate or his cell) suggested the inmate's clothing had fallen down to his ankles because he had lost a significant amount of weight during his confinement. The issue of clothing worn at the time of death only serves as a distraction to other facts in this high profile case. All the available evidence, including, but not limited to, the condition of the inmate's cell when he was found hanging (e.g., careful placement of family pictures and Bible), as well as the increasing tone of frustration and annoyance voiced in his journal entries, and the reality of spending the remainder of his natural life in prison subjected to harassment from others, points to suicide.

Following his death, a variety of writing material was found in the inmate's cell. He had written in journal fashion beginning on August 10, a mere five days after his CRC arrival, and ending approximately on the day of his suicide (September 3). The themes in much of his journal entries concerned the behavior of some correctional staff and an obsession regarding the quality of food. He also appeared to write with a sense of entitlement. On August 10, he complained of rude officers ("This is the first guard in this institution that mistreats me, for no apparent reason") and food not being "warm." (He also wrote similar complaints in journal entries on both August 11 and August 13). On August 14, he wrote in journal fashion that "I really think someone tampered with my food." He wrote of having chest pains around 6:45pm and then throwing up (a complaint that was confirmed by his medical records). On August 22, he wrote that his cell and toilet were filthy, and he asked an officer for a mop to clean. He also asked for clean linen and underwear, stating "still nothing gets done. I don't know if I can take this neglect anymore, and the way I'm being treated." The inmate wrote of his complaints about food on almost a daily basis, complaining that there was hair and plastic in his food, and that it was always served in "a pool of water," and he ended up flushing most of it down the toilet. On August 28, he wrote that "I'm really getting frustrated." On August 31, the inmate wrote that "I will not take this kind of treatment much longer if this place treats me this way, I can only imagine what things would be like at my parent institution.... I feel as though I'm being pushed over the edge, one day at a time." The following day (September 1), he wrote that "a supervisor asked for my soiled underclothing to be washed. It's nearly 9:00pm, still no underclothing to wear," then wrote that the supervisor said "my brown rice looks like dog shit."

The inmate also penned a four-page "A Day in the Life of a Prisoner" beginning on August 10 in which he wrote that "I eat, brush, and go back to bed, get up, lay down, get up, lay down. This goes on all day....I pace in my cell, meditate, stare at the walls as I daydream a lot...." Many of the entries are undated, introspective, at times future-oriented, but other times filled with despair. For example, he wrote that "As for me, I will never see light at the end of the tunnel, but that's all right, it's what I chose.... I've lots of time on my hands now to think and read, write, exercise. I want to make a bigger effort to try to commit to god.... I wonder how warm the cell will be in winter, for I'm very sensitive to cold draft. It literally drives me to get under the covers.... I also get depressed and don't want to do anything but just lay here, I guess we'll just have to wait and see when I get to that bridge....Most of the guards here are okay, but the younger ones don't take the job seriously or they are rude to me for no apparent reason....Sometimes I drift into a negative thought, I check myself and try harder not to go there."

Review of numerous photographs taken of the inmate's cell following his death by the consultant team indicated several personal items were intentionally placed in specific locations in the cell. For example, a Bible (left open to chapters 2 and 3 of the Gospel of John) was carefully arranged on his bunk. A placard with photographs of numerous family members was on the desk leaning against a wall, and sheets of paper with family names and Bible verses were all carefully arranged and gave the appearance of a shrine; all seemingly assembled in preparation for death.

Summary: There were several areas of concern in this case. Although a few correctional staff failed to conduct many of the required rounds at 30-minute intervals during the shift on September 3, as well as then falsifying unit logs, the rounds were properly conducted at the time that the inmate was found hanging. Further, although both correctional and medical personnel responded in a timely fashion to the medical emergency, it appeared that EMS personnel were untimely called approximately seven (7) minutes after notification of the emergency and CPR initiation, and it took EMS personnel approximately 40 minutes to respond to the scene. It appeared that several officers assigned to the segregation unit had either not received the specialized mental health training or had not received it in many years. The two mental health clinicians who had the most interaction with the inmate documented comprehensive progress notes and assessments.

The CRC psychology supervisor that we interviewed appeared both conscientious and highly competent. It was, therefore, surprising that the CCCC discharge summary form and LorCI mental health records were not reviewed by this clinician. The significance of failing to review these documents remains uncertain. In addition, although the records did not reflect any evidence the inmate was displaying any imminent signs of suicidal ideation during confinement, the CRC clinician's recommendation that "mental health should monitor periodically for any change in mental status or lethality risk" was vague and should have contained a specific timeframe for follow-up (e.g., 1 week, 2 weeks, or 4 weeks, etc.). It was noteworthy that the mortality review form completed in this case was very comprehensive. Finally, it remains unclear whether or not the inmate was verbally harassed by facility staff and/or other inmates. The inmate's reality, as reflected in his journal entries, suggested perceived harassment from both, as well as an obsession regarding his food and cleanliness of his cell. His writings presented conflicting thoughts, from being future-oriented to profound frustration and despair about day-to-day life. In conclusion, based upon the fact that this inmate was going to remain in prison for the rest of his natural life under the probability of continued perceived harassment and threats to his safety, his death was not predictable on September 3, 2013, but his suicide was not surprising and perhaps inevitable.

Summary

From review of these 16 inmate suicides, the following information is noteworthy:

- Apart from one inmate serving a death sentence and another serving life without parole, the average minimum sentence remaining to serve of inmates committing suicide was 18 years;

- 14 of 16 (88%) inmates had been convicted of violent crimes (most involving murder and/or rape); 2 inmates were serving time for parole revocations;

- The average time served prior to suicide was 65 months; excluding the shortest time served of 9 hours and longest time served of 25 years, the average time served for the remaining 14 inmates was 53 months;

- 9 of 16 (56%) inmates were housed in either segregation (7 inmates, including death row) or classified in a housing unit (2 inmates in Level 4B) in which they were only allowed out of their cells 5 hours a week and had other prohibitions similar to an inmate confined in segregation;

- All of the segregation or other specialized housing units that experienced suicides were staffed by corrections officers that either did not have specialized mental health training or had not received such training in many years;

- 7 of 16 (44%) inmates were on the mental health caseload at the time of their death, and an additional 4 (25%) inmates had mental health histories and were not yet classified or had been discharged from the caseload; only 5 inmates (31%) had no identified history of mental illness;

- 11 of 16 (69%) inmates had a history of suicidal and/or self-injurious behavior;

- 5 of 16 (31%) inmates had a family history of suicide or suicide attempts;

- All 16 of the cases involved a timely emergency medical response, however, several cases involved incidents in which problems arose in the response, e.g., either a backboard was not used, emergency medical services (EMS) were untimely called or untimely arrived at the scene; and

- 6 of 16 (38%) of the cases involved problems in timely completion of required cell checks, including several cases of falsified documentation.

In addition, although the DRC mortality review process currently does not require inquiry regarding possible precipitating factors to an inmate suicide, the consultant team's review of these deaths chronicled the following possible *precipitating* factors (with several cases involved multiple factors):

- canceled visit from girlfriend based upon ending the relationship;
- increased fear and anxiety regarding personal safety;
- court denial of sentence appeal;
- recent ending of relationship with partner;
- harassment from other inmates regarding sex offender status;
- increased anxiety and agitation regarding impending prison transfer;

- removal from special programming and preferred housing;
- recent suicide of brother;
- imminent execution; and
- inability to endure lengthy prison sentence

C. LEGAL FRAMEWORK FOR CUSTODIAL SUICIDE: A HIGH PROFILE CASE

Inmate Ariel Castro is a trigger event for this investigation. DRC asked that the consultant team examine the legal aspects of this case as well as lessons to be learned from the event. Thus, this case has been used as the stalking horse for a more detailed examination of the law on custodial suicide.

Inmate Castro's particular circumstances are frequently referenced here within that legal framework. Our overall assessment on liability exposure in that case is that the primary components necessary to establish such liability are lacking in this case. There was officer misconduct in the falsification of certain records and some reason to believe that second-shift officers verbally harassed this high profile inmate.

There also is some confusion about whether Inmate Castro was regarded as a suicide threat prior to being transferred to CRC, but CRC mental health staff clearly did not review definitive information on point. Without a recent attempt or threat in this particular case, it is virtually impossible to find deliberate indifference to a serious risk of suicide.

The case law on liability for custodial suicide is littered with findings and rulings that make it extremely difficult for plaintiffs to prevail in such cases. See generally, Fred Cohen, *Practical*

Guide to Correctional Mental Health and the Law, ch. 13 (Civic Research Institute, Inc. 2011)(hereafter, Cohen, Practical Guide). The constitutional standard for liability in the federal courts is that the defendant must be deliberately indifferent to a high degree of risk of suicide.[5] Thus, negligence, mere inadvertence, is insufficient. There must be actual knowledge of a particular vulnerability to suicide; the knowledge must create a strong likelihood, versus the possibility, of suicide and this strong likelihood must be so obvious that a lay person would easily recognize the need for responsive, preventive action.[6]

"Prison officials need only take reasonable precautions to prevent inmate suicide; they do not insure or guarantee the life of a prisoner." *Galloway v. Anuszkiewicz*, 518 Fed.Appx 330, 334 (6th Cir. 2013) citing *Danese v. Asman*, 875 F.2d 1239, 1245 (6th Cir. 1989).

Even where prison officials perceive a serious suicide risk, liability still will be averted if the ultimately unsuccessful response was "reasonable." *Comstock v. McCrary*, 273 F.3d 693, 706 (6th Cir. 2001). Absent a credible, recent threat to commit suicide or knowledge of a recent attempt, the courts are extremely reluctant to impose liability. See *Bell v. Stigers*, 937 F.2d 1340 (8th Cir. 1991).

In Inmate Castro's case, there were multiple, properly administered mental health assessments that produced nothing that would require a mental health-suicide prevention intervention.[7] The

[5]At times, the "high degree" requirement conflates the degree of certainty with the potential imminence of the event. In Inmate Castro's case, there is nothing to be gained in unbundling the two concepts because neither is present on the basis of this investigation.
[6]See the frequently cited *Colburn v. Upper Darby Township*, 946 F.2d 1017, 1024-24 (3rd Cir. 1999)
[7]Inmate Castro was received at LorCI on August 2, 2013 at 6:25pm and received initial mental health and medical screenings. He was evaluated by a mental health professional on August 3, 2013 and August 4, 2013. A

inmate's status as a "high profile" inmate and his particular crimes, however, clearly suggested that he could be at risk of harm from other inmates and quite possibly be the target of verbal abuse. The nature and duration of this inmate's crimes incited strong emotions in the Cleveland community and beyond. Indeed, a key reason for DRC officials in moving this inmate from LorCI to CRC was to ameliorate the potential for harm to him from other inmates. Elaborate precautions to protect this inmate were immediately initiated at CRC, including extreme limits on inmate and staff contact with him.

There are two major tracks for custodial suicide liability: (1) failure to provide ameliorative, and possibly preventive, mental health care that may also include confinement in the straightened circumstances of a "safe cell" and (2) failure to protect the inmate from the risk of self-harm.[8] Clearly, DRC officials did not perceive the need for any drastic (e.g., safe cell confinement), mental health intervention or the imposition of close or constant watch.

Officials did perceive a threat to this inmate's physical safety from others and he was immediately housed in protective custody at CRC. We must emphasize that this was not to protect him from self-harm. It was designed to, and did, protect him from harm from other inmates. The physical conditions related to this cell and the level of staff observation cannot be measured by what would be appropriate for a suicide watch.

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precautionary security watch was invoked but not due to any suicide indicators. On August 5, 2013, he was again seen by a mental health professional and watch precautions were discontinued.

[8]See Cohen, Practical Guide at 13-2-(3) for a listing of the nine liability theories (or basis) raised by plaintiffs. At 13-5-[2]-[a], "failure to train" is discussed in some detail indicating its remoteness in this case.

The CRC cell in which Inmate Castro was confined is a second tier, corner cell. It was selected by officials because of the minimal inmate traffic in that area. The cell itself could not be described as a suicide safe cell in that there were multiple tie-off points, including the shower, where the hanging would have been more out of view and more easily accomplished than the barely accessible window hinge from which the inmate hung himself. A safe cell would require more in the way of visibility into the cell as well.

It is actual knowledge of a high degree of suicide risk that is required for liability. Did the high profile status of this case equate with actual knowledge of a high degree of suicide risk? Did the nature of the offenses or even the inmate's purported self-diagnosis as a "sex addict" somehow create the requisite actual knowledge of risk?

Recall, there was an unclear history of suicide attempts or threats and nothing in the multiple risk assessments by DRC professionals that created actual knowledge of a high degree of suicide risk.[9] Again, the high profile-notoriety aspects of his offenses did, indeed, suggest a risk of physical harm by other inmates. If Inmate Castro had been placed in general population or in open proximity to other inmates and he was then injured or killed, a strong case for deliberate indifference could be presented.[10]

[9] A recent "Evidence Synthesis" by the Kaiser Permanente Center for Health Research, "Screening for Suicide Risk in Primary Care: A Systematic Evidence Review for the U.S. Preventive Services Task Force" (April 2013), grimly concluded, "Suicide screening is of high national importance. It is very difficult, however to predict who will die from suicide, and there are many inherent difficulties in establishing the effectiveness of treatment to reduce suicide and suicide attempts. Limited evidence suggests that primary care-feasible screening instruments may be able to identify adults at increased risk of suicide, and psychotherapy targeting suicide prevention can be an effective treatment in adults." In the realm of inmate suicides, however, research has shown that suicide rates have been reduced and, therefore, deaths prevented, while accurately predicting when an inmate will exactly attempt suicide remains challenging.

[10]David Berkowitz, New York's "Son of Sam," was attacked by fellow inmates and the resultant slash wound took 56 stitches to close. (David Abrahamson, Confessions of Son of Sam (NYU Press, 1985)). New York inmates

A reader may well have the nagging feeling that the offenses and Inmate Castro's dissociative statements about the normalcy, even happiness, of his fortress household situation strongly suggest mental illness; a double-life that included delusions. Let us stipulate to that suggestion for the purposes of discussion.

For liability to attach, the argument would have to be that some serious mental illness should have been identified and treated and, if it had been, it is likely that this inmate would not have committed suicide. Psychiatrist James Knoll, M.D., an expert in custodial suicide, in writing about mental hospital suicides notes that bipolar disorder, followed by depression and then schizophrenia are the high risk illness indicators. Even mere disagreement with a diagnosis does not establish deliberate indifference.

Dr. Knoll emphasizes that the clinical root cause of custodial suicide is a failure of clinical assessment and there is no such failure in this case.[11] There is no DSM IV (or V) Axis I diagnosis and none of the required high risk categories. There is no correlation between his supposed delusional double life and an elevated risk of self-harm. Even if some mental health treatment had been extended, whether individual counseling or medication, or both, it is entirely speculative that the treatment would have prevented the suicide, particularly since the suicide occurred so early (33 days) into his DRC confinement. Liability exposure does not rest on such conjecture.

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interviewed by Fred Cohen indicated that Berkowitz was at risk due to the randomness of his shootings "Could have been my sister." Jeffrey Dahmer, the notorious cannibalistic killer, was attacked by an inmate in prison first on July 1994 when returning from a church service. His throat was slashed. Four months later, Dahmer was bludgeoned to death by an avenging inmate while in a prison bathroom. (New York Times (Nov. 1994)).

[11]James L. Knoll, IV, M.D., Legal Armor for the Psychiatrist, p. 4 (2012). This material is used in a course at S.U.N.Y. Upstate Medical University for forensic fellows. The multiple assessments conducted on this inmate produced no indicators for suicide risk. See *Gray v. City of Detroit*, 399 F.3d 612, 616 (6th Cir. 2005), holding there is no general right to suicide screening.

Looking beyond the possible liability aspects of this matter, it may be helpful for DRC to revise the relevant policy & procedure and require the assignment of a mental health professional to an Inmate Castro-like, newly entering prison inmate. Regular contact with such an inmate could reduce the inmate's likely anxiety and provide an ongoing record of behavioral signs. This is a policy-oriented consideration and not a legally-driven procedure.

Specific criteria for "high profile" inmates would have to be developed along with clearly stated objectives including the limited duration of this extraordinary process. There may not be wisdom in hindsight but there are previews; previews that provide lessons to be learned and go beyond the narrow compass of legal liability.

Over the years, DRC has shown a willingness to take the extra step and this suggested extra step should be carefully considered.

Could this suicide; indeed, could all prison suicides, have been prevented? Yes, of course. This would have meant placing a Castro-like inmate on constant watch, every minute of every day. He would not have even a semblance of privacy and the cost factor would be enormous. This, hypothetically, could have been done but the issue is whether it should, or must, have been done.

DRC follows the commendable policy of using the least restrictive and intrusive means for a suicide watch. As noted, the protective custody response here was not designed as a response to suicidality. It was a reasonable response to external danger; it was designed to be protective.

Converting the protection from others to protection from self is not part of the legal duty calculus here. A hypothetical constant (or even close) watch was not called for on the basis of suicidality or the need to protect this inmate.

Alleged Officer Misconduct

During our October 8 and 9, 2013 visit to CRC, the consultant team heard rumors from some inmates that Inmate Castro had been verbally harassed by certain officers and particularly so during the second shift.[12] Mr. Hayes first picked up these rumors on our October 8, 2013 tour of the segregation unit where the suicide occurred.

On October 9, 2013, Mr. Cohen met privately with four inmates who volunteered to talk and who were housed in the unit during Inmate Castro's relatively brief (30 days) stay.

During investigator Cohen's one and one-half hour (appx.) group session, the cadre inmates spoke as one in describing the alleged verbal harassment by officers directed at this inmate. For example, Inmate Castro complained about his food and was heard to ask, "What am I eating?" The officer's alleged response: "You're eating shit," "You're a piece of shit," or "It's dog food."

These same inmates were adamant that Inmate Castro came in weighing, maybe, 250 pounds and he was, maybe, 190 when he died. In fact, Inmate Castro weighed 178 upon arrival to DRC and was 168 pounds at the time of his autopsy. There is a weight loss, of course, but not so precipitous nor at such an extreme absolute weight as reported.

[12]Inmate Castro also complained in his writings about being verbally hassled by inmates. We were unable to confirm or reject the validity of this complaint. Only if staff instigated or took no steps to halt the most extreme form of such harassment would there be a liability issue.

These inmates also reported that Inmate Castro was somehow not permitted to change his bedding nor clean his cell. When the inmate allegedly asked about recreation, he allegedly was told by officers, “You don’t deserve it. Never gave them girls recreation.” We were not able to confirm this account.

There were relatively few inmates on the unit when this suicide occurred. It is a quiet unit where such verbal exchanges might be heard. The Highway Patrol, after an initial investigation, was asked to return to the unit and interview these same inmates after Cohen verbally communicated with DRC officials his concerns about the supposed verbal harassment.

Two new investigators were sent and subsequently reported that there were too many inconsistencies (not specified to me) for the inmate accounts to be treated as credible.

Let us take another, and different, approach. We will use a stipulative-arguendo approach and simply stipulate, without endorsing the truth, that some officers verbally harassed and also may have effectively denied Inmate Castro any out-of-cell recreation.

As a matter of policy and internal discipline, this is a matter that DRC should carefully further investigate and also make absolutely clear to staff that their job does not include the infliction of additional punishment of even the most loathsome inmate. As for establishing a possible causal connection between the alleged harassment and the suicide, no such connection appears to exist even accepting the worst of what allegedly was said to Inmate Castro over the 30-day period.

There is a considerable causal distance between this type of alleged verbal harassment for the relatively brief period of time it may have occurred and the actual suicide. Inmate Castro's behavior belies any assertion that there was a direct cause and effect between the alleged harassment and the suicide. His journal entries speak to increased frustration and agitation, but no specific talk of suicide. His visits from family and plans expressed for his future (having a guitar, e.g.) provide no hint of suicidal despair. On the other hand, DRC officials are urged to treat the allegations of harassment in this case as sufficiently credible to reinforce policy and training in this area.

Even if one argues that Inmate Castro's somewhat "normal prison" behavior was merely a cover for a man bent on self-destruction, the argument itself undermines liability exposure: deliberate indifference requires actual knowledge of a high degree of risk. In other words, a stellar performance by an inmate that eliminates suicidality also eliminates the requisite actual knowledge requirement.

Inmate Castro had his protective custody hearing the day he committed suicide. The inmate reportedly asked the sergeant conducting the hearing where he would be after leaving CRC; would he be closer to family? These questions and concerns, of course, are inconsistent with a person likely to commit suicide and if they were intended to mislead, then they did.[13]

Rounds in protective custody are to be conducted at least every 30 minutes and are to be staggered. DRC officials early on found discrepancies in those rounds. The discrepancies

[13]The sergeant told the consultant team that there were more precautions taken to protect this inmate than anything he could recall in 22 years.

ripened into actual falsification when five of these rounds, colloquially referred to as simply "living and breathing" rounds, were found to be falsely recorded as having been completed.[14]

While rounds that were recorded as being done earlier in the day were not actually done, there is video showing that the final completed round was recorded at 8:54pm and Inmate Castro was alive. At 9:18pm, he was found hanging and unresponsive. Thus, he was seen alive 24 minutes prior to the hanging and that is within the time interval for these rounds.

This in no way excuses the falsification of important records. The seriousness of this practice is heightened by the falsification of similar records surrounding the suicide of Inmate Billy Slagle who committed suicide at CCI days before his scheduled execution. This, again, is a matter for internal discipline, training and reinforcement of the necessity and objectives for these rounds.

Are the multiple falsifications in Inmate Castro's records and a failure to perform multiple rounds a causal factor in this suicide? It does not appear to be so. The rounds (or observation) were not suicide prevention rounds, which would have been more frequent and directed at behavior more expansive than "living and breathing." Had there been no observation for a greater period of time than actually occurred then some "what if" speculation would be in order. The 24-minute interval, as noted, from observation to hanging is within the time period that these types of rounds permit.

[14]According to DRC records, the logs were falsified at 3:03pm, 3:32pm, 5:00pm, 7:45pm, and 8:15pm. The rounds at 8:45pm and 9:15pm were properly conducted and Inmate Castro was observed hanging at 9:18pm.

This is a serious policy issue; it is relevant to the suicide-liability inquiry but the needed legal, causal relationship between the earlier derelictions and the suicide appears to be lacking.

D. RECOMMENDATIONS AND CONCLUSIONS

Based upon review of numerous policies and procedures related to suicide prevention, training curricula, case review of 16 inmate suicides, interviews with numerous correctional, medical, and mental health officials and staff from the DRC, as well as observation of practices, the consultant team formulated several conclusions and recommendations for systemic corrective action. Such offerings will be provided to DRC during a secondary phase of this project and consistent with the agency's confidential continuous quality improvement process.

It is tempting to equate any errors and omissions by staff as a cause of a custodial suicide but succumbing to temptation would not be accurate for legal liability. Any such errors must equate with the demanding requirements of deliberate indifference and also be the proximate cause of an inmate's suicide. However, liability exposure and adjustments to policy and procedure involve different considerations.

We were asked to provide a legal analysis of these two cases and also address ameliorative or possibly preventive measures as a set of "lessons learned" from these events. In that spirit, we recommend:

1. The adoption of enhanced mental health staff involvement with "high profile" inmates as per the discussion at Section C, pg. 18.
2. Immediate action to correct a culture that has allowed officer falsification of logs related to security rounds, as well as better accountability of corrections supervisors.
3. The reinvigoration of the earlier, more rigorous staff training on custodial suicide and ending of the use of on-line, electronic training courses.
4. The enlargement of agreements with counties to enhance the receipt of their records, which may have relevant, suicide risk information.
5. A closer examination of the uses of mental health observation and close watch statuses.

There is a sense of failure when an inmate in one's custody decides to end his or her life. It is dispiriting to staff and depending on who and how a suicide is committed, a suicide may become a media event. Indeed, the public has a right to know and it is unusual for a corrections department to be so transparent as to release a document such as this.

Correctional staff should perform as though all suicides can be prevented; that gestures, threats, and attempts must be taken seriously. There are almost 37,000 deaths by suicide a year in the open community, while 80% of those attempting suicide have a psychiatric illness at the time of the attempt.[15]

Death by suicide is all too common and obviously not limited to penal institutions. Penal institutions, however, have the duty to protect the life of those in their custody and it is an

[15] Kaiser Permanente Research Affiliates Evidence-based Practice Center, Screening for Suicide Risk in Primary Care: A Systematic Evidence Review for the U.S. Preventive Services Task Force, AHRQ Publication No. 13-05188-EF-1 (April 2013)

obligation we determined that DRC takes seriously. The two suicides analyzed here had high profile status, for different reasons obviously, but neither can be attributed to the failure of DRC staff.