



LGIT'S COMMANDER'S LOG

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LIABILITY OF CORRECTIONAL SUPERVISORS AND LOCAL GOVERNMENTS FOR SUICIDE COMMITTED BY A PRETRIAL DETAINEE

QUESTION: Can a local government be liable under a federal civil rights statute (42 U.S.C. § 1983) for the suicide of a pretrial detainee solely on the basis that it employed the shift commander in charge at the time of the occurrence? Can a correctional center shift commander/supervisor be liable solely on the basis that the suicide occurred while he was in charge?

ANSWER: The answer to both questions is “No”. The local government can be liable only if its policies or customs resulted in the death of the detainee. The supervisor can be liable only if he actually knew of and disregarded the detainee’s serious medical needs or a substantial risk of harm to the detainee.

CASE: *Cortez v. Prince George's County, Maryland*, 31 Fed. Appx. 123
United States Court of Appeals for the Fourth Circuit, Decided March 22, 2002

In *Cortez v. Prince George's County, Maryland*, the United States Court of Appeals for the Fourth Circuit once again considered the elements needed to establish the liability, under a federal civil rights statute, of municipalities and supervisors in the correctional setting.

In the *Cortez* case, the facts showed that on October 14, 1996, at approximately 2:00 a.m., Antonio Cortez, a detainee at the Prince George’s County Correctional Center, was found hanging in his cell, having hanged himself from the top of a bunk bed by using his shoelaces. The death was ruled a suicide by the medical examiner. While in custody prior to his suicide, Cortez exhibited specific symptoms that indicated he would attempt suicide. As a result of the death, Cortez’s estate sued, among others, the County, the Director of the County’s Department of Corrections, and the Shift Commander at the time of the suicide.

According to the lawsuit filed by Cortez’s estate, Major W. Johnson, the Shift Commander at the time of the suicide, “knowingly disregarded the clearly identifiable and known risks that [Cortez] exhibited specific symptomatology which warranted full psychiatric assessment and treatment and would attempt to commit suicide.” As a result, the lawsuit read, Major Johnson refused to provide adequate treatment, care, evaluation and protection of Antonio Cortez for his specific symptomatology. The lawsuit further stated that “these deliberate acts and omissions resulted in [Cortez’s] being subjected to physical and mental pain and suffering and ultimately . . . death.” It was also stated in the lawsuit that, at the time of these events, Prince George’s County maintained a policy and custom of failing to provide detainees with adequate medical diagnosis and treatment, and of failing to train correctional officials and medical providers to provide detainees with adequate medical and mental health screening, evaluation and follow-up. Finally, the lawsuit alleged that

Prince George's County maintained a policy and custom of failing to provide detainees with protection from clearly identified and known risks of suicide.

In response to the lawsuit, the County, the Director of the Department of Corrections, and Major Johnson moved to dismiss. Their motions were granted, and Cortez's estate appealed only the dismissals of the County and Major Johnson.

On appeal, the United States Court of Appeals reversed the dismissal entered in favor of Major Johnson. The Court concluded that the lawsuit contained sufficient allegations that Major Johnson was deliberately indifferent to the serious medical needs of a pretrial detainee and/or a substantial risk of harm to a pretrial detainee to survive a motion to dismiss. The Court also reversed the dismissal of these claims against the County. In doing so, the Court recounted the elements of these kinds of claims against supervisory officials. Concerning the "deliberate indifference" claims against Major Johnson, the estate of Cortez was required to plead, and, ultimately, would have to prove, that Major Johnson (1) actually knew of and disregarded Cortez's serious medical needs or that (2) Major Johnson actually knew of and disregarded a substantial risk of serious harm to Cortez. Since the allegations in the lawsuit sufficiently alleged these elements, dismissal, at least at this early stage of the legal proceedings, was inappropriate.

Concerning the County, the Court first noted that it could not be liable simply on the basis that it employed Major Johnson. Rather, the County could only be liable if a policy or custom resulted in Cortez's death. In other words, the County could only be liable if the alleged unconstitutional conduct of Major Johnson represented or carried out official County policy or custom. A local government's failure to train its employees can result in § 1983 liability only when such failure reflects a deliberate indifference on the part of the local government to the rights of its citizens, that is, only where a failure to train reflects a deliberate or conscious choice by the local government. Since it was alleged in the lawsuit filed by Cortez's estate that the County maintained a policy of failing to train correctional officials to provide inmates with obvious symptomatology of suicidal risk with adequate medical and mental health screening, and/or of failing to provide inmates such as Cortez with protection from clearly identified and known risks of suicide, and that these policies resulted in Cortez's suicide, dismissal at this early stage of the litigation was inappropriate.

NOTE: Given that prisoners, such as Cortez, are in the custody of the state, the law imputes a duty upon the state and prison officials to provide adequate medical treatment, including psychiatric or psychological therapy. Thus, the *Cortez* case serves as a reminder to local governments to ensure that their correctional employees are adequately trained to recognize, and screen for, signs of psychological illness, problems or conditions that pose suicidal risk. Obviously, an expression of suicide or suicidal ideation by a detainee at any point in his or her incarceration should be taken seriously, and all reasonable steps should be taken to prevent such occurrence. Such steps may include prompt evaluation or re-evaluation by medical staff, increased monitoring by correctional officers, and/or removal to cells where monitoring of detainees is constant. Any suicidal thoughts or threats made to a correctional officer, or of which the officer becomes aware, should immediately be reported to the Shift Commander or other supervisor in charge.

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