CTAS

County Technical Assistance Service

UT INSTITUTE FOR PUBLIC SERVICE

Jail Liability - 2026

Jim Hart, Jail Management Consultant

Most lawsuits do not start in court!

- They happen on the average day, on the average shift, in the average manner that we conduct business.
- Liability –
- Successful claims show a failure in either practice or policy.
- Shortcuts become habits or the “new norm”.

Risk Management Premises

- Courts will look for past complaints.
  - Were complaints investigated
  - What did the complaints find?
  - If a policy violation occurred, was the matter addressed appropriately?
- What does the policy say?
  - Is it in practice? Is the policy current?
  - Have staff been trained in the policy?
  - How often? How/who authored the curriculum?
- Policies are often developed in reaction to an incident.
  - Get input from practitioners.
  - Annual review process legal and bi-annual.
  - Accreditation/Certification?

Risk Management

- Do you know the specific liabilities your jail is faced with?
  - How do you document that you are aware of and manage these liabilities?
- Are your policies and procedures thorough?
  - Do they require data collection to document compliance?
  - Is anyone assigned to manage, collect, analyze the data?
  - Who reviews the data, who discusses the data, are there formal corrective action plans developed?
  - Can you prove it?
- Do staff follow policy and procedure?
  - How do you audit this?
- Are there complete and credible investigations of incidents?
  - Including self-harm and deaths in custody?
  - Who conducts them? Are they qualified?
  - Are there recommendations that effect changes to policies, procedures, training, oversight, adjustment to auditing compliance?
  - Can you prove it?

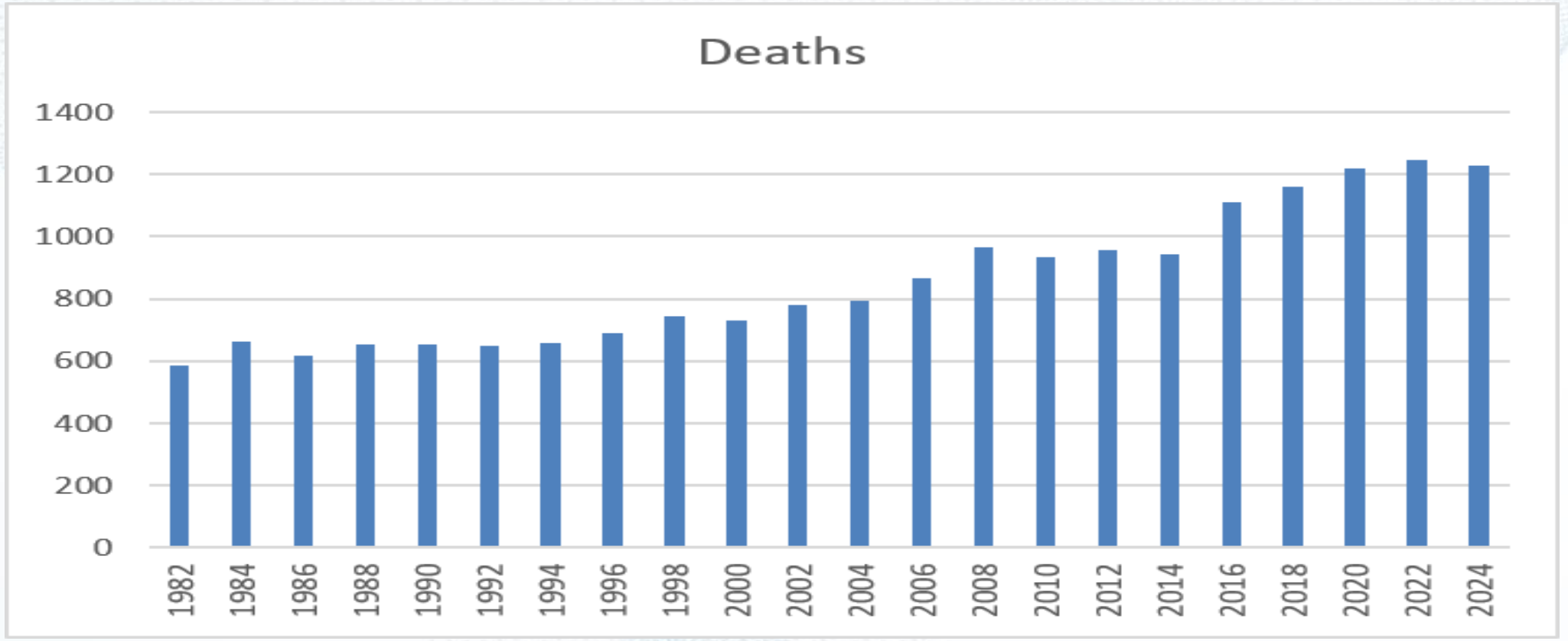
Failure to Protect – Relevant Issues

- Types & level of violence
- Reported vs. actual incidents
- Types of injuries
- Gangs
- Housing unit design
- Classification
- Weapons
- Staff
- Documentation
- Security precautions
- Defective security equipment
- “Even where officials are actually aware of substantial risk of serious harm to an inmate, they may be found free of liability if they responded reasonably to the risk even if the harm is not averted.” - Farmer v. Brennan

Jail Suicide Awareness

Suicides in Tennessee Over the Years

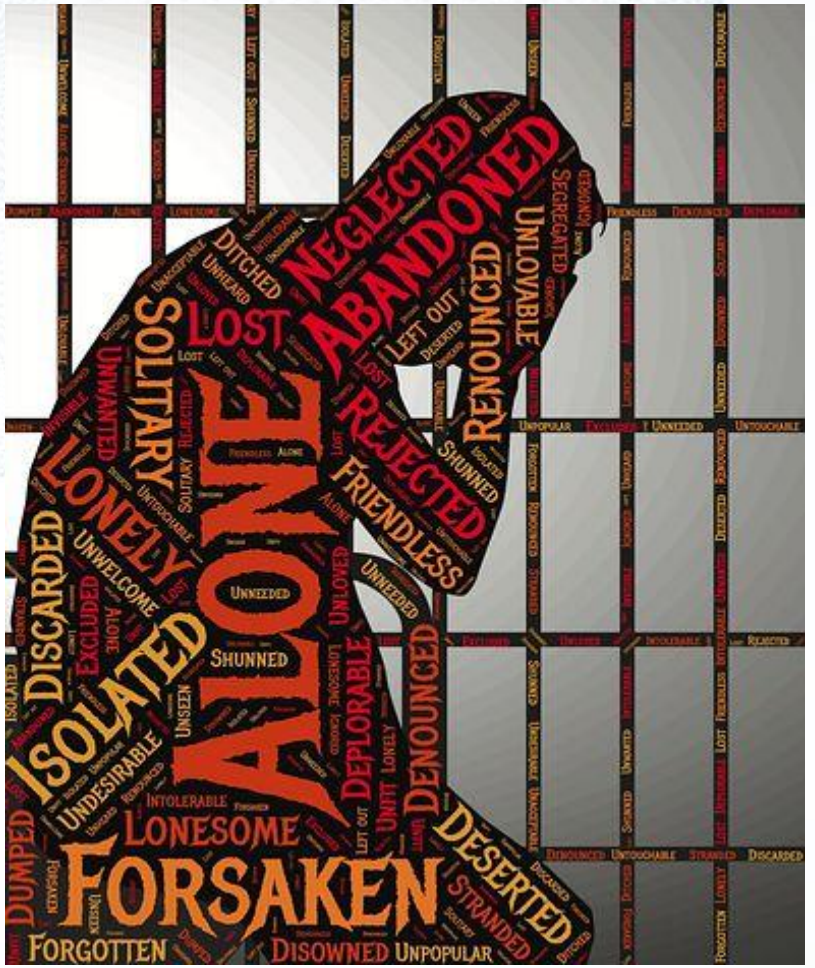
Source: Status of Suicide in Tennessee 2023 Tennessee Suicide Prevention Network



Suicide Detection and Prevention

Suicides in jails

Suicides in the community



Rate of suicide within jails is 3 times+ greater than in the community.

Tennessee's Minimum Standards for Local Correctional Facilities - Personnel

1400-01-.06(3)(b).

- "…all detention facility employees, support employees, and non-facility support staff shall receive orientation training…"

1400-01-.06(6)(b).

- "All non-facility support staff who have regular or daily inmate contact, shall receive a minimum of four hours continuing annual training…"

Tennessee's Minimum Standards for Local Correctional Facilities
Medical Services

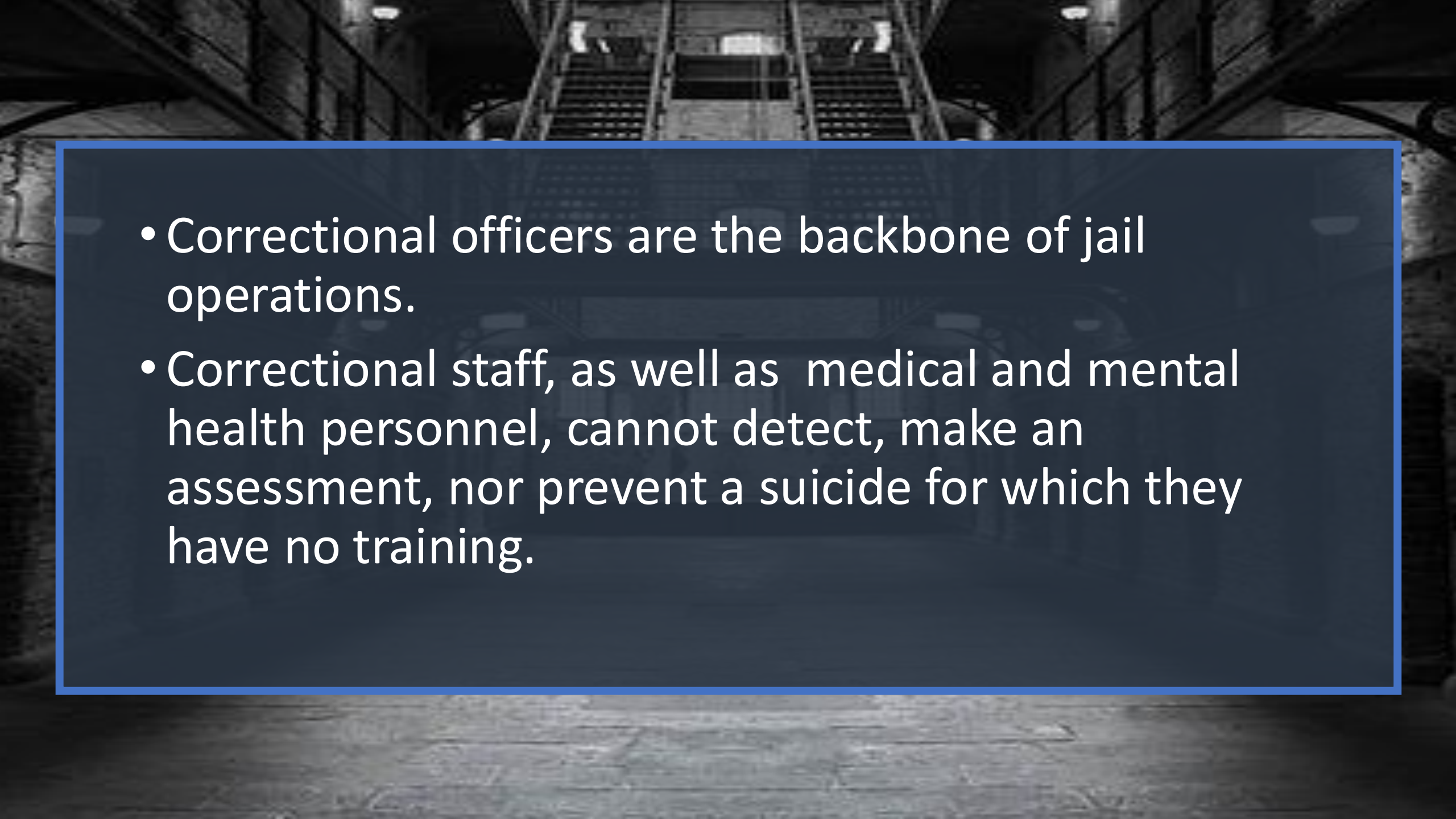
1400-01-.13(7)(e).
• "Receiving screening shall be performed on all inmates upon admission to the facility and before placement in the general housing area. The findings shall be recorded on a printed screening form."

1400-01-.13(12).
• "A suicide prevention program shall be approved by the health authority and reviewed by the facility administrator. The program must include specific procedures…All facility employees responsible for supervising suicide-prone inmates shall be trained annually..."

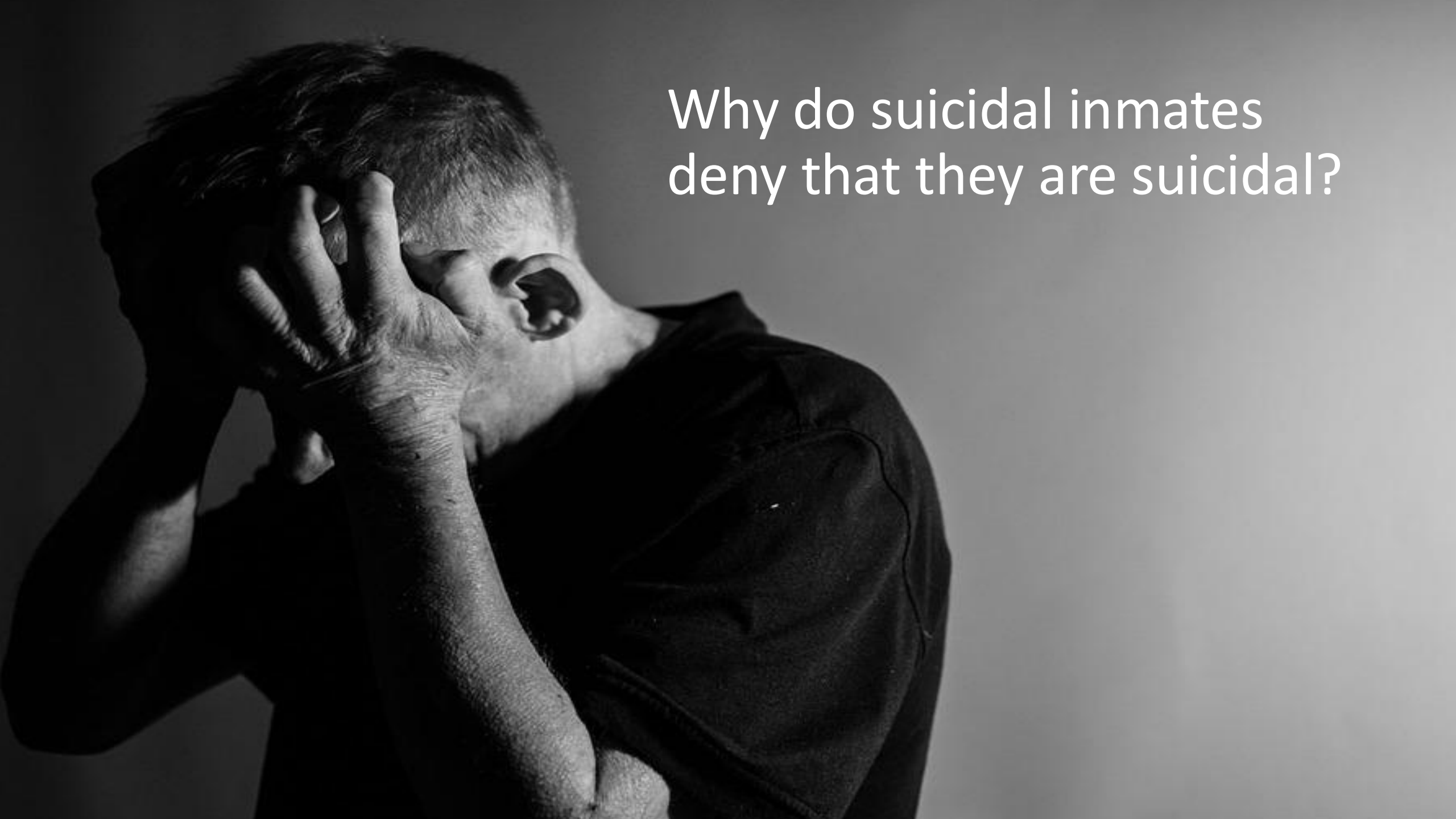
Screening v. Assessment

- Screening:
  - Usually a one-time event.
  - Brief “yes/no” questions.
  - Due not definitively diagnose a specific condition or disorder.
  - Used at admission to jail or during other special situations.

- Assessment:
  - In-depth process involving a comprehensive examination by a QMHP.
  - Not a one-time event, an ongoing process during at-risk patients' incarceration.
  - Includes a thorough evaluation of the individual’s history.
  - Assist in identifying key risk factors.
  - Typically integrate results from multiple sources.
  - Includes sufficient description of the current behavior and justification for the intervention being provided.



- Correctional officers are the backbone of jail operations.
- Correctional staff, as well as medical and mental health personnel, cannot detect, make an assessment, nor prevent a suicide for which they have no training.


Why do suicidal inmates deny that they are suicidal?

Characteristics of Suicides

Deaths were evenly distributed throughout the year, certain seasons and/or holidays did not account for more suicides.

32% occurred between 3:01 p.m. and 9 p.m.

23% occurred within the first 24 hours, 27% occurred between 2 and 14 days, and 20% occurred between 1 and 4 months after incarceration.

20% were intoxicated at the time of death.

93% used hanging as the method.

66% used bedding as the instrument.

Characteristics That Make Correctional Environments Conducive to Suicidal Behavior

- AUTHORITARIAN ENVIRONMENT
- NO APPARENT CONTROL OVER THE FUTURE
- ISOLATION FROM FAMILY, FRIENDS, COMMUNITY
- SHAME OF INCARCERATION
- DEHUMANIZING ASPECT OF INCARCERATION
- FEARS (REAL AND PERCEIVED)
- REACTION TO CERTAIN OFFENSES BY INMATE SUBCULTURE

Safe Housing

- Avoid isolation to every extent possible.
- Housing assignments should be based on the ability to maximize staff interaction

  - **Suicide resistant**
  - **Unless indicated by mental health staff, continue to receive regular privileges**

Summary: Possible Precipitating Factors ("Stressors")

Conflicts within Institutional Environment

Interpersonal Conflicts

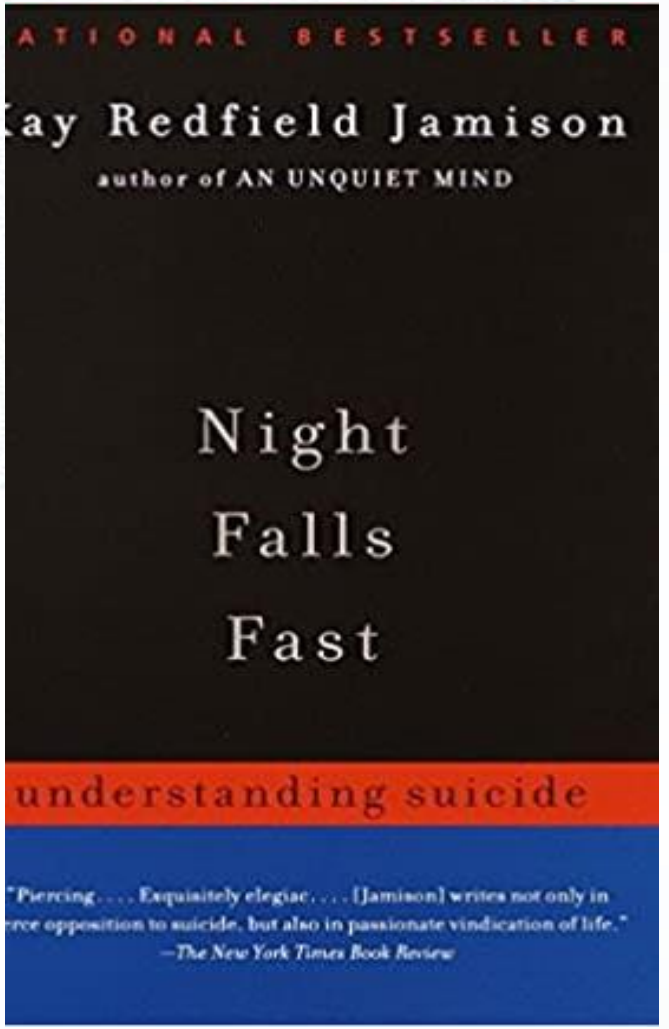
Negative Consequences from the Legal Process

Controversial Issues in Suicide Prevention

- No suicide contracts.
- Stripping a potentially suicidal inmate naked/issuance of smock or different colored uniform.
- Using CCTV and inmate companions as alternatives to staff observation.
- Policy of “never entering a cell without backup”.
- When no vital signs exist, don’t presume that death has occurred.
- Protecting the Scene of the Crime.
- Rating Scales

Guiding Principles to Suicide Prevention

- Great job of safely managing suicidal inmates.
- Our struggle – those not easily identifiable.
- “Were suicidal patients able or willing to articulate the severity of their suicidal thoughts and plans, little risk would exist.” Kay Redfield Jamison



Guiding Principles to Suicide Prevention

- The assessment of suicide risk should not be viewed as a single event, but as an ongoing process.
- Screening for suicide risk during the initial booking and intake process should be viewed as something like taking one's temperature – it can identify a current fever, but not a future cold.
- Prior risk of suicide is strongly related to future risk.

Guiding Principles to Suicide Prevention

- Many jail suicides also occur near a court hearing, visit, or telephone call.
- A disproportionate number of inmate suicides take place in special housing units.
- Provide meaningful suicide prevention training to staff.
- Many preventable suicides result from poor communication amongst correctional, medical, and mental health staff.

Guiding Principles to Suicide Prevention

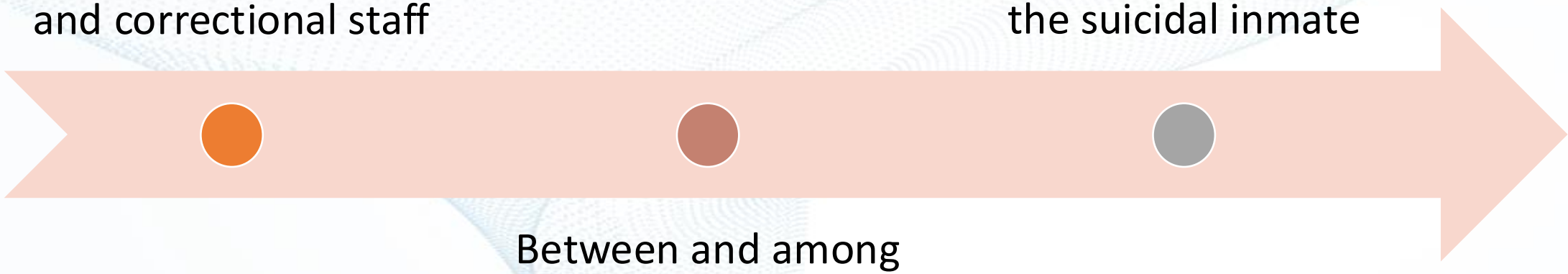
- A lack of inmates on suicide precautions???
- Avoid using the terms “Watch Closely” or “Keep an Eye On Him/Her”…
- Avoid obstacles to prevention.
- Create and maintain one comprehensive suicide prevention program…

3 Stages of Communication to Prevent Suicides

Between arresting/ transporting officer and correctional staff

Between and among staff (correctional, medical, and mental health)

Between staff and the suicidal inmate



Use of Force


ONLY ON 7
EYEWITNESS NEWS
VIDEO SHOWS JAIL ATTENDANT BEATING INMATE


SHERIFF


BREAKING NEWS
25 Correctional Officers Indicted
On Excessive Force Charges

Duty to Intervene Theory…..

- Willis v. Baca
  - “Any deputy present and observing another deputy using force that is clearly beyond that which is objectively reasonable under the circumstances shall, when in a position to do so, intercede to prevent the use of such excessive force.
  - A deputy who observes another employee use force which exceeds the degree of physical force permitted by law should promptly report these observations to a supervisor.”

Duty to Intervene
Lexipol Duty to Intercede Webinar, July 7, 2020

- Focus on the small areas that can create large problems.
- Time Matters. "Liability will be imposed only if the bystander officer or supervisor has sufficient time to prevent the unlawful act."
- A police officer is under a duty to intercede and prevent fellow officers from subjecting a citizen to excessive force and may be held liable for his failure to do so if he observes the use of force and has sufficient time to act to prevent it." Figueroa v. Mazza, 825 F.3d 89, 106 (2nd Cir. 2016).
- "Generally speaking, a police officer who fails to act to prevent the use of excessive force may be held liable when (1) the officer observed or had reason to know that excessive force would be or was being used, and (2) the officer had both the opportunity and the means to prevent the harm from occurring." Turner v. Scott, 119 F.3d 425, 429 (6th Cir. 1997)
- 7th CIRCUIT: PLAINTIFF MUST PROVE…
  - Officer alleged to have committed primary violation used excessive force on Plaintiff.
  - Defendant knew that Officer was/was about to use excessive force on Plaintiff.
  - Defendant had a realistic opportunity to do something to prevent harm from occurring.
  - Defendant failed to take reasonable steps to prevent harm from occurring.
  - Defendant's failure to act caused Plaintiff to suffer harm.

Duty to Intervene
Lexipol Duty to Intercede Webinar, July 7, 2020

- Trust in what your fellow officer is doing is critical!
- Need to recognize when another CO needs to “tap out”.
- “It was just a matter of time before Smith did something like that.”
- Lexipol suggested policy: 512.3.2 DUTY TO INTERCEDE
  - Any officer present and observing another staff member using force that is clearly not within this policy is expected, when reasonable to do so, to intercede to prevent the use of such force and in all cases report the use promptly to a supervisor.
- Aviation – Crew Resource Management (CRM)
  - The individual components of CRM resources are communications, situational awareness, problem solving, decision making, and teamwork.
- Medicine – CRM
  - Four tenants: Team responsibility for care; a belief/understanding for fallibility; peer monitoring; and team member awareness of care status, team member status and available resources.

Duty to Intervene
Lexipol Duty to Intercede Webinar, July 7, 2020

- Law Enforcement – CRM
  - Sources of risk:
    - Malice – attitude "don't care"
    - Lack of training/experience/skill – when was the last unarmed self-defense class held by the agency?
    - Anger – Huge problem; spit on, feces thrown, punched, etc….. You are human first – anger must however be controlled.
    - Hormonal dump to fear/strong emotional response – adrenalin rush, focused on the event, lose focus of your specific actions (how you were trained to respond).
- Legitimacy as a Guide – it is legal and the right thing to do!
  - Solid legal foundation: policy, training, practice consistent with both, level of response appropriate.
  - Solid safety foundation: The actions ensure the safety and security of the inmate, staff, and others in the area. Are the actions consistent with the penological goals of the agency?
  - Solid goals and objectives for actions: Can you articulate your rationale for the reason for force and the level of force employed? Can you articulate the reasons for your actions (as a responder)?

Duty to Intervene
Lexipol Duty to Intercede Webinar, July 7, 2020

- Consider:
  - Have a duty to intercede policy.
  - All officers must understand what duty to intercede entails.
  - Duty to intercede must be built into agency culture
  - Training should involve scenarios to identify the need for and practice interceding (reinforce policy).

Duty to Intercede and the Five Pillars of Organizational Risk Management – Lexipol October 15, 2021

- Establish and clearly communicate organizational values to agency members and reinforce them through training, supervision and discipline.
- Train officers on the realities of human performance in high-stress events.
- Conduct thorough background investigations.
- Develop a supervisory process to review incident reports, use of force reports, disciplinary reports…
- Utilize an early warning system.
- Establish an audit system of incident video recordings.

Lessons Learned

- After incident reviews (informal)
  - BRIEFING? TRAINING? POLICY? DISCIPLINARY?
- Looking “forward”/critical to avoid allegations of “custom, policy or practice”
- “Self Audit” is a strong defense to ward off allegations of deliberate indifference

USE OF FORCE: Hudson v. McMillian, 112 S.Ct. 995 (1992)

- Key Factors in determining whether excessive force (malicious and sadistic) was used?
- 1. Threat perceived by a reasonable officer.
- 2. Need for Use of Force
- 3. Amount of Force used in relation to the need for force
- 4. Effort(s) made to temper forceful response
- 5. Extent of the Injury
  - A. Exigent circumstances: one factor to be considered in determining whether the use of force was wanton and unnecessary.
  - B. All other use of force scenarios- serious injury is not a requirement.

Kingsley v. Hendrickson
June 22, 2015

- Objective unreasonableness.
- District Court “force applied recklessly that is unreasonable…”
- 7th Circuit “subjective inquiry”…
- Supreme Court - objective unreasonableness
  - Threat perceived by a reasonable officer.
  - Need for use of force as the appropriate response to the perceived threat;
  - Amount of force used in relation to the need for force;
  - Effort(s) made to temper the severity of the forceful response; and
  - Extent of the injury to the inmate (one factor to be considered);
  - Severity of the security problem at issue; and,
  - Whether the plaintiff was actively resisting.

Use of Force – Incident Review

- Do you do an after-incident review? What does that consist of?
- Post incident medical assessment? Why?
- Is having staff involved in the incident reviewing video recordings when preparing reports an acceptable practice?
- Who is required to submit a report after an incident?
- Macro view?

Remember in the Report

- A detailed narrative is required
  - The inmate was combative; the inmate was resisting…
  - That does not paint the picture of what was going on and why you chose to do what you did
- Describe what the inmate was actually doing.
  - In today's world this is more important than ever. Paint the picture to defend your actions.
- As a result of the inmate's actions, the officer responded in this manner (rationale).
  - The courts give substantial deference to you – articulate your legitimate governmental interest of why the force you employed was necessary.
- Critical review by supervisors, adherence to your policies and procedures, your training, your supervisory guidance.
  - If not consistent, address it. Establish this culture!

Medical Considerations

Hunger Strikes

- What do you do with an inmate on a “hunger strike”?
- Types of Hunger Strikes:
  - Food refuser
  - True food refuser
- Hunger Strike Food Intake:
  - Dry
  - Total
  - Non-total

Hunger Strikes

- Physician engagement
- A good rule of thumb “72 hours”
- Segregate and monitor
- Mental health exam
- Daily vitals
- Hunger strike ends…

What is a Mortality Review?

- NCCHC Standard J-A-10 provides a good explanation:
- Standard: All deaths are reviewed to determine the appropriateness of clinical care; to ascertain whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study.
- Compliance Indicators:
    1. All deaths are reviewed with in 30 days.
    2. A death review consists of:
        a. An administrative review
        b. A clinical mortality review
        c. A psychological autopsy if death is by suicide
    3. Treating staff are informed of the clinical mortality review and administrative review findings.
    4. All aspects of the standard are addressed by written policy and defined procedures.

Three Key questions asked:

1. Could the medical response at the time of death be improved?
2. Was an earlier intervention possible?
3. Independent of the cause of death, is there any way to improve patient care?

- TN Minimum Standard for Local Correctional Facilities1400.01-.13(33): "The health authority shall develop and approve protocols for identifying and evaluating major risk management events related to inmate health care, including inmate deaths, preventable adverse outcomes, and serious medication errors."

Minimizing Medical Lawsuits
Marc F. Stern MD, MPH, 10 Ways to Avoid Medical Lawsuits

- Inmate medications being taken in the community.
- Drug and alcohol withdrawal is done safely.
- A strong suicide prevention program.
- Judicious use of restricted housing for mentally ill inmates.
- High quality restricted housing welfare checks by medical.
- Rational Hepatitis C treatment decisions.
- “Medical said he was okay”…
- Orders for tests, medications, consults, are completed.
- LPN’s work within the abilities and scope of their license.
- Shift emphasis in management philosophy from the “person” who erred to the “system” that is broken.
- Use external reviews.
- The #1 thing that you can do to avoid health care lawsuits…

Minimizing Medical Lawsuits
Marc F. Stern MD, MPH, 10 Ways to Avoid Medical Lawsuits

- Rational Hepatitis C treatment decisions.
  - Are medications stopped at intake?
  - Are there protocols and documentation in place?
    - 2.2 million people in U.S. jails and prisons (1 in 3) have Hepatitis C.
    - Common ways someone can get Hepatitis C – blood, drugs, tattoos/piecing/scarring, and sex.
    - Prevention: don't use tattooing, piercing, or cutting equipment that has been used on others; don't share needles or other equipment used to inject drugs; don't share razors, toothbrushes, or other personal items that may have come into contact with another person's blood.
    - (Center for Disease Control and Prevention – www.cdc.gov/hepatitis)
- "Medical said he was okay"…
  - Empowerment to do the right thing!
  - Is there deterioration or is it "crying wolf"?
- Orders for tests, medications, consults, are completed.
  - Are they executed and timely?
  - Is short staffing our argument?
  - What is the process for getting test and lab results to medical after an appointment?

Documenting Medication Administration – in general

- There does not appear to be a Sixth Circuit categorical rule requiring every correctional officer to sign/initial an MAR.
- The facility's own medication-distribution procedure is extremely important.
- A MAR is evidence, not necessarily conclusive proof.

Minimizing the Risk

Falling out of a Top Bunk Leads to Inmate Death

Lovett v. Herbert and Overton No. 17-1668, U. S. Court of Appeals, 7th Cir., October 29, 2018

- Daniel Martin arrested for drunk driving and booked into the Clay County Indiana Jail. Fell out of an upper bunk suffering injuries that lead to death.
- Housed in cell 4.
- The mattress policy says?
- CO's file motion for summary judgement and sought qualified immunity for their conduct. The district court said – no. "…there are competing versions of what occurred…"
- Ultimately the court answered "were the events so obviously foreseeable that the Fourth Amendment requirement of reasonable conduct would have given the officer's notice that their actions violated that standard?
- The Appellate Court reverses the Circuit Court decision regarding summary judgement

Cell #	Capacity	Housed
1	2	1 male (Threat to other inmates)
2	2	2 males
3	2	1 female
4	2	1 male
5	2	1 female federal inmate
6	2	1 male (threat to other inmates)
Padded Cell	1	Empty
Medical Isolation	1	1
Drunk Tank	14	9 ICE inmates – 0 bunks

Safe, Clean, and Well-Maintained Physical Environment

- Jails should…
  - Keep the jail clean and in good repair
  - Establish written safety, sanitation, and preventive maintenance plans
  - Establish an internal system of inspections to regularly assess the level of sanitation and condition of the jail
  - Promptly correct any deficiencies identified by external inspection authorities

Risk Reduction

- Policy and procedures
  - Adherence
  - Documentation of compliance.
  - Be proactive
  - Is there a “weak link”
  - When does the county attorney get involved
  - Supervisor responsibility
  - Compare the video against the reports

Effective measures to reduce risk can include, but are not limited to:

- Written operation policies (reviewed annually)
- Hiring and employee selection and promotion procedures
- Staff training programs – are you committed to a professional training program or, are you just checking the box???
- Validated Inmate classification processes
- Working security and communications systems
- Annual Training and practice in life safety and other emergency responses
- Services that meet the constitutional minima of offender needs and protection
- Routine inspections to maintain preventative maintenance and basic sanitation
- Create a Professional Standards Compliance Unit!
- Citizen Advisory Committees or Review Boards

Managing Risk in Jails, Martin and Reis, National Institute of Corrections, April 2008, p. ix

Affirmative Duty

- The legal obligation to act as a corrections professional based on:
  - A presumption that public officials know constitutional law and are required to take positive steps to discharge that duty.
  - To comply with the constitutional duty, the public expectation is exhibited in the daily recourse or discharging of your duties and business affairs.
  - Sworn duty as a corrections officer or deputy sheriff, by an oath of office or position.
  - Guiding state statues and correctional standards.
  - Training attended.
  - Post orders, job descriptions.
  - Supervisory empowerment.
  - The situation confronted with and doing the right thing in the face of adversity or when no one is around watching.

Inmate Grievances – Necessary?

Prison Litigation Reform Act

PLRA 18 USC Section 3226 enacted in 1996 by Congress.

- One of the most important developments in prisoner litigation.
- Has the **effect of discouraging frivolous litigation**. Has reduced the number of section 1983 lawsuits by almost half.
- PLRA **does not apply** in state court actions.
  - Some states (Pennsylvania, Utah, and Wisconsin) have adopted legislation which mirrors PLRA.
- Under the PLRA, **"[n]o action shall be brought** with respect to prison conditions… by a prisoner confined in any jail, prison, or other correctional facility **until such administrative remedies as are available are exhausted."** 42 U.S.C. section 1997e(a). **"[T]he PLRA pre-filing exhaustion requirement is mandatory and non-discretionary."**
- Burden is on the Defense to prove the plaintiff did not exhaust their administrative remedies.
- The Courts continue to affirm the need under PLRA for a currently confined inmate to exhaust their administrative remedies or the lawsuit will be dismissed. Baltas v. Jones 162 F. 4th 68 (2nd Cir. 2025); Johnson v. Bienkoski, 2025 WL 2504823 (3rd Cir. 2025); Dennis v. Howard, 2025 WL 2607624 (6th Cir. 2025); Breyley v. Fuchs, 156 F. 4th 845 (7th Cir. 2025); Wiggins v. Hatch, 2025 WL 2925385 (10th Cir. 2025); and Savage v. United States Department of Justice, 91 F. 4th 480 (D.C. Cir. 2024).

Inmate Grievances

- Do you have a grievance system?
- How do you process them?
- What about those constant, irritating grievances?

Designed to help staff as much as they are inmates:
- A method for dealing with issues.
- Minimize the likelihood of inmate-initiated lawsuits.
- May lessen the likelihood that a lawsuit will succeed in court.

Religious Head Coverings – Religious Diets Your Practice?

Religious Head Coverings

Religious Head Coverings

- Newly arrived inmate wearing a head covering.
- Jail issued religious head coverings?
- Photographing
- What about religious head coverings in general programs, general population, courts?
- What if an inmate requests a religious head covering after entering confinement?
- Can they be taken away?
- As always, staff training!

Religious Diet Requests

- Religious Land Use and Institutionalized Persons Act (RLUIPA).
- Steps to consider when evaluating a request:
  - Require a written application.
  - Conduct a sincerity interview.
  - Review facility behavior.
  - Consider consulting with outside resources.
  - Document the decision.
  - For those approved, monitor compliance.

Implementing New Procedures? Responding to Requests for Change?

- Turner v. Safley
- “The Turner Test”

Searches

- Types of Searches:
- Pat-down searches: Physical Touching:
  - The least intrusive method. Involves a clothed search by running hands over the body.
- Strip Searches: Visual – No touching.
  - Involves the removal of some or all clothing for a visual inspection of the naked body, including visual inspection of body cavities.
- Body Cavity searches: Probing.
  - The most invasive search, involving the physical probing or digital inspection. This requires a high degree of individualized suspicion or a search warrant and is often required by policy to be performed by a licensed medical professional rather than correctional staff.

Protecting your agency from liability

- Know the law – keep current
- Walk and talk. Get in housing units and constantly evaluate the conditions of confinement – interact with your staff on their posts.
- Be accessible to communicate.
- Set the benchmarks for your facility – intake screening, classification, types of supervision…
- Audit your operations – quality control.
- Innovate – Be a best practice leader!
- Invite stakeholders' comments, tours, reviews – they won’t come? Keep inviting!
- Train and train some more – budget for it.
- Monitor vendor contracts and adherence to specifications.
- Act don’t react.
- Do your job!

Final Thoughts on Jail Liability

- How often do you tour all areas of the jail?
- Are you preparing your future leaders?
- What does policy and procedure review in your agency consist of?
- Is staff training effective? Or is it simply “we’re getting it done”?
- Celebrate National Corrections Officer Week, National Volunteer Week, Pride in Food Services Week, Administrative Professionals Week, National Nurses Day.
- What contracts do you have? Who is monitoring them?
- What is the data telling you (bookings, releases, ADP, probation violators, recidivism, evidenced based programs, trends in significant incidents, meal costs, mileage…)?
- What are you doing to better educate yourselves on effective jail operations?

Jail Liability

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