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How to be Best Prepared for the Death of an Inmate in Custody

From our partners at Jones Passodelis, PLLC.

It is one of every warden's worst fears: an inmate dies in custody. A death in a county jail sets off a whirlwind of events—calls from distraught and angry family members about their loved ones, calls from members of the prison board about what happened, and calls from the press. With any death in custody, regardless of the cause, a civil rights lawsuit is likely. Allegations of deliberate indifference to serious medical needs, reckless indifference to a particular vulnerability to suicide, and failure to protect inmates from harm at the hands of others are some of the most common—and most serious—claims filed. How can you be best prepared to respond to all of these inquiries and any resulting lawsuit?

What happens in the days and weeks following such an event will have a tremendous impact if and when a lawsuit is later filed. The following list, while not exhaustive for every scenario, covers some best practices in the event of a death in custody.

1. Prepare a record of the events. Incident reports should be prepared by all jail officials involved including any jail contractor (like medical personnel, for example) who interacted with the inmate during the relevant time. These should be gathered early when memories are most fresh. A timely incident report preserves the important details and provides credible evidence of what each person experienced. If the death occurred close in time to the intake of the inmate, a report from the intake officer as to the inmate's condition or demeanor may be critical and should be preserved in a report, particularly if the inmate records on the intake are not sufficiently detailed. If the death did not occur close in time to the intake, but much later in the incarceration, relevant medical or mental health records should be secured to show any ongoing care that might connect to the death.

Inmates who may have witnessed important events, such as cellmates, should be interviewed both to preserve their recollections and to prevent them from later changing their stories about what happened. This can be important even if the cellmate did not witness the death. For example, the cellmate may have information about whether, in a suicide case, the inmate talked about suicide or said anything to an officer, whether the inmate asked for medical care, etc. At times, preserving what the inmate did not say is just as important as what was said. For example, an inmate stating that another inmate who committed suicide never told anyone about being suicidal can be powerful evidence.

2. Preserve all evidence. Beyond the obvious need to preserve all physical evidence, video evidence must be secured, as it plays a critical role in a subsequent lawsuit. Surveillance systems typically overwrite video on a

recurrent basis, making early preservation critical so that it is not lost. The best practice is to preserve all video of an inmate, whether it appears to be relevant to the death or not. What does not seem to be important at the time of the investigation can prove to be very important later, because it is almost impossible to determine what theories will be developed by a clever attorney. If evidence is not preserved, a claim of “spoliation” may result, which could lead to an adverse inference in a lawsuit that the failure to preserve the video is an indication that what was depicted was negative for the county. Preserve all video—cell video, video from the inmate at booking, video showing movement throughout the facility, video from the block/pod—to prevent it from being overwritten.

It is also important to preserve all emails, texts and related forms of electronic communications for the same reason. Similarly, an inmate’s telephone calls are powerful evidence of their state of mind and can play an important role in future litigation. Speak with your IT personnel to make sure this data is secured.

3. Advise law enforcement. In most instances, contact law enforcement (county detectives, state or local police, the coroner) to do an independent investigation of the death. In addition to determining whether any crime has been committed, the creation of an independent investigation may prove helpful in subsequent civil lawsuits.

4. Make the appropriate reports to state and federal authorities. An Extraordinary Occurrence Report is required to be completed and submitted to the Pennsylvania Department of Corrections. The Federal Death in Custody Act now requires aggregation of mortality data from county jails so logging such incidents will ensure compliance and ease for reporting.

5. Report the matter to PCoRP or the county's insurer. Making PCoRP aware is an obligation under the terms of your coverage, and failure to provide a timely report could jeopardize coverage. After a coverage review, PCoRP will frequently assign counsel to assist you with your investigation and preparation in the event a lawsuit is filed. While traditional insurers may not provide investigative support like PCoRP, this is a proactive approach that is taken in the best interest of the Member and the program.

6. Assess any violations of policy. Conduct an internal review as to what occurred and whether policy was followed. If a lawsuit is filed, the opposing attorney will ask whether you did, and if you did not, why. If policy was followed, any report should note that finding but it should be supported by evidence gathered. If an employee violated policy, that should be noted as well and action should be taken to address the violation. In civil rights cases, which would be the style of case for a death in custody, unlike in standard negligence cases, a county is not liable simply because an employee acted inappropriately. If it was a failure to follow a proper policy that caused a problem, and the employees were aware of that policy, the county is not necessarily liable.

7. Preserve the policies/inmate handbook in place. Preserve versions of the relevant policies that were in effect at the time of the death, as well as a copy of the inmate handbook. They will be relevant and necessary for a lawsuit. If review of the death leads to a recommendation for changes to policies, do not let the fact of the death stop you from making necessary changes. Learning from these unfortunate events is a critical part of any good operation.

A death in custody could certainly be viewed as a nightmare. Being prepared to deal with this dramatic scenario will allow a warden and the county to rest a little easier if all efforts have been made to put your best foot forward in dealing with the aftermath.