Holding Cell Supervision

BACKGROUND

The decedent had been arrested after becoming belligerent and violent while being treated at a local hospital. A doctor's report noted that the individual displayed signs of emotional distress, information which was not communicated to the arresting officer. After the formal arrest and intake, the decedent was placed in a holding cell fully clothed and still holding his hospital gown. The police department had a formal policy stating that prisoners would be checked at least every 30 minutes and a mental health (suicide) screening to be completed as part of the intake process.

SCENARIO

After approximately 25 minutes in the holding cell, the decedent began to act erratically — climbing on the sink, covering the in-cell CCTV, and crying uncontrollably. Fifteen minutes later, while still crying, the individual tied his hospital gown around the cell doors and removed his sweatshirt. Five minutes later, the decedent looked directly into the cell's camera and tied the sweatshirt around his neck. He then attempted to secure himself to the top cross bar, which was above his reach. He then tied his sweatshirt to the second highest cross bar, then dropped his weight, causing the sweatshirt to stretch and release. After five additional minutes, he once again tied the sweatshirt around his neck and this time he successfully climbed to the top cross bar of the cell doors and secured his sweatshirt. He dropped his weight again and hanged himself. Police officers arrived and unfortunately, they had difficulty in opening the cell doors because of the tied hospital gown and sweatshirt, causing additional delay in cell entry and rescue. Once the officers gained access, they successfully cut the sweatshirt to free him, and performed CPR until Fire and EMS personnel arrived. The decedent was transported to the hospital where he died from his injuries.

LESSONS LEARNED

The incident might have been prevented with regular training on SOPs regarding detainee assessment, intake, and supervision. Specifically:

- The decedent was placed in cell with several non-essential items.
- The required 30-minute cell checks were not performed.

RECOMMENDED BEST PRACTICES

CIRMA suggests the following:

- Police departments should review their prisoner supervision, assessment, and intake policies.
- Police departments should implement policies that require both routine time-based prisoner checks and more frequent time-based checks for high-risk prisoners.
- Police departments should train all dispatchers, desk officers, and any other personnel who have the responsibility for prisoner supervision on the departmental policies that address audio/visual equipment used in prisoner detention and lock-up facilities.
- Police departments should document their supervision efforts to record when the cell checks are completed.
- Police departments should implement a policy prohibiting non-essential items in holding cells, thus limiting the use of cutlery, drink containers, and loose fabric or clothing that could be used to harm the detainee or officers.
- Police departments should document mental health screenings in accordance with their SOPs.
- Police departments should ensure that routine maintenance inspections include prisoner detention and lock-up facilities.
- Police departments should consider safe location areas in or near prisoner detention and lock-up facilities to house tools or devices to perform emergency entry into cells.

Questions? Ask your Supervisor or contact your CIRMA Risk Management Consultant at (203) 946-3700.

Connecticut Interlocal Risk Management Agency