No. 24 -

IN THE

SUPREME COURT OF THE UNITED STATES

ANNE FRANCISCO, THURMAN FRANCISCO, and TYLER FRANCISCO,

Petitioners,

v.

JASON ENGLAND, MICHAEL GRIFFIN, GREGORY RHODES, and KIMBERLY SCALLION,

Respondents.

On Petition for Writ of Certiorari To the United States Court of Appeals For the Eighth Circuit

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PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

The Eighth Amendment prohibits prison guards from intentionally denying or delaying access to medical care. Respondents failed to immediately start suicide watch when they were informed Joshua Francisco was suicidal by other inmates, they observed he was crying and upset, and knew he had previously been on suicide watch, and disciplinary segregation was imposed for his refusal to go to a special mental health unit. The questions presented, upon which the circuits are deeply divided:

1. Whether evidence that corrections staff were found in violation of written prison suicide intervention procedures requiring them to immediately start suicide watch when they knew the inmate was a serious suicide risk is proof of deliberate indifference in an Eighth Amendment claim for intentionally denying prompt mental health care?

2. What evidence of deliberate indifference is sufficient to defeat qualified immunity for corrections staff at the summary judgment stage in an Eighth Amendment claim for intentionally denying prompt mental health care for a suicidal prisoner?

LIST OF PARTIES

Petitioners are the parents, Anne and Thurman Francisco, and Tyler Francisco adult child of Joshua Francisco (deceased).

Respondents are Gregory Rhodes, Kimberly Scallion, Jason England, and Michael Griffin.

LIST OF PROCEEDINGS

This case directly relates to the following proceedings:

Francisco, et al. v. Corizon, Inc., et al., case number 4:17CV1455 HEA, United States District Court for the Eastern District of Missouri. Final judgment entered December 27, 2022.

Francisco, et al. v. Corizon, Inc., et al., case number No. 23-1036, United States Court of Appeals for the Eighth Circuit. Decision on July 26, 2024.

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The District Court decision granting summary judgment motions based on qualified immunity are reported at *Francisco v. Corizon Health, Inc.*, 2022 WL 17961183 (E.D. Mo., Dec. 27, 2022). (Appendix C App 15 c).

The decision of affirmance by the United States Court of Appeals for the Eighth Circuit is published: *Francisco v. Corizon Health, Inc.*, 108 F.4th 1072 (8th Cir. 2024). (Appendix A App 2 a).

STATEMENT OF BASIS FOR JURISDICTION

The Eighth Circuit entered its decision affirming the grant of summary judgment for qualified immunity to all Respondents on July 26, 2024.

The Eighth Circuit denied timely petitions for panel and en banc rehearing on September 3, 2024. (Appendix B App 14b).

This Court has jurisdiction to entertain the Petition for Writ of Certiorari pursuant to 28 U.S.C. § 1254.

CONSTITUTIONAL PROVISION AND STATUTE INVOLVED IN THE CASE

U.S. Const. amend. VIII states:

> "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."

42 U.S.C. § 1983 states, in pertinent part:

> "Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress …".

STATEMENT OF THE CASE

Come now Petitioners, by counsel, and submit their Petition for Writ of Certiorari. The Eighth Circuit's decision conflicts with other Circuits holding that evidence correctional officers violated prison policy requiring them to start suicide intervention when they received information a prisoner was suicidal is relevant to the issue of deliberate indifference to serious medical needs. The decision also conflicts with this Court and other Circuits on the sufficiency of proof of deliberate indifference to defeat qualified immunity at the summary judgment stage. The facts are largely undisputed. The inferences to be drawn from the evidence whether the officers exhibited deliberate indifference to Francisco's serious mental health needs presented material fact questions. Petitioners' case presents an ideal vehicle for resolving the conflicts in the law.

A. Factual Background

Joshua Francisco committed suicide by hanging himself on his 112th day in prison. He was age 39. During a marital dissolution proceeding, his then wife obtained an order of protection. He pleaded guilty to aggravated stalking for violating the order of protection by calling, emailing, and trying to make in-person contact with her. Subsequently, the marriage was dissolved and his ex-wife obtained sole custody of his daughter. He was imprisoned for three years after his probation was revoked for attempting to call his ex-wife to speak with his daughter when he was in a psychiatric center (ROA 5-6; R. Doc. 1-5,6).

July 2, 2014, Joshua was transferred from the St. Louis County, Missouri Jail on "high suicide risk in the psychiatric infirmary" to State custody (ROA 485; R.Doc. 110-24) (all dates are in 2014 unless otherwise specified). He was moved to Farmington Correctional Center (FCC) a few weeks later (ROA 358-9; R.Doc.110-2 at 4-5). The Missouri Department of Corrections (DOC) contracted with Corizon to provide medical and mental health care at FCC (ROA 112; R.Doc.95-1 at 93).

Respondent Kimberly Scallion's job as a correctional case manager in the administrative segregation unit (Ad Seg) was to check on prisoners' non-medical needs (ROA 363; R.Doc.110-4 at 3). Scallion had no mental health role, was not to make psychiatric risk assessments, and had to follow written DOC policies (ROA 372-3; R.Doc. 110-4 at 12). She knew in July Joshua had been in a mental hospital and informed Corizon of his problems. She knew he had been on suicide watch several times and

was accepted for transfer to the Social Rehabilitation Unit (SRU), a specialty mental health facility, before the third week of October 2014 (ROA 364, 366; R.Doc.110-4 at 4,6). Staff discussed Joshua "every day" because he was one of "our suicide guys" (ROA 364; R.Doc.110-4 at 4). Scallion knew Joshua's case was difficult because he did not believe he was mentally ill (ROA 374; R.Doc. 110-4 at 14).

Respondent Gregory Rhodes was functional unit manager (FUM) in Ad Seg. As "head administrator" he performed inmate custody status hearings, reviewed inmate files, inspected the premises and custody staff, security, scheduling and inmate mental health (ROA 377, 380; R.Doc.110-5 at 2,5). All DOC staff in Ad Seg reported to him (ROA 379; R.Doc.110-5 at 4). At all relevant times, Rhodes knew of Joshua's "serious mental health issues" (ROA 381, 462, 476; R.Doc.110-5 at 6, 110-16 at 1, 110-19 at 1), that he was approved for SRU admission, and "had been on suicide watch" at FCC (*Id*. and ROA 382, 396, 399, 462, 476; R.Doc.110-5 at 7 and 21; 110-6, 16, 19). He knew only "very mentally ill offenders" were approved for SRU admission (ROA 156; R. Doc. 95-8 at 12).

Respondent Michael Griffin was a "wing officer" in Ad Seg responsible for checks on prisoners two times per hour, security, and counting prisoners (ROA 402; R. Doc. 110-7 at 3). Griffin knew he was not to make mental health assessments (ROA 421; R. Doc. 110-7 at 22). Prior to October 22 Griffin knew Joshua had been on suicide watch (ROA 404, 416; R. Doc. 110-7 at 5,17) and was approved for SRU (ROA 413; R. Doc. 110-7 at 14).

Respondent Jason England was a sergeant. He was temporarily assigned to Ad Seg on October 22 "due to staff shortage and the ad seg unit is more of a critical post" (ROA 425-6; R. Doc. 110-8 at 3-4). He was told by Rhodes immediately after his encounter with Joshua about the history of being on suicide watch (ROA 428; R. Doc. 110-8 at 6).

July 15 Joshua was classified "MH-4" meaning he needed "intensive or long-term inpatient or residential psychiatric treatment at the (SRU)" and/or "frequent psychological contacts and psychotropic medications" (ROA 439; R. Doc. 110-9). His diagnosis was bipolar affective disorder; rapid cycling, mixed; paranoid delusional disorder; and polysubstance abuse (ROA 410; R. Doc. 110-10). September 16 a hearing panel ordered Joshua to receive involuntary medication (ROA 117-29; R. Doc. 95-4 at 9-13). He received injections of Haldol, an anti-psychotic medication (ROA 443-4; R. Doc. 110-12 at 2-3).

Joshua was placed on suicide watch four times, for a total of 37 days through the end of September 2014 at FCC (ROA 445-8; R. Doc. 110-13 at 1-4). September 3, Joshua cut himself on the wrist with a broken light bulb, an "SR-2" event - suicide attempt (ROA 149, 442; R. Doc. 95-8 at 5, 110-13 at 3). Placement on suicide watch required handcuffing, removal from cell, strip search, smock (ROA 420; R. Doc. 110-7 at 21), and housing in a camera cell (ROA 458; R. Doc. 110-14 at 10).

October 2, Joshua was placed on protective custody (PC) in Ad Seg by the DOC classification committee headed by Rhodes (ROA 462; R. Doc. 110-16 at 1). In Ad Seg, inmate privileges are restricted: no personal

or written contact with general population of prison, limited showers, no razors, no contact visits, no phone calls to family, limited canteen and reading materials, and recreation three hours per week (ROA 466; R. Doc. 110-17 at 7-10).

October 8, Joshua was approved for SRU admission but had to be off PC status for transfer. SRU is a separate mental health unit with 100 beds where MH-4 level inmates receive intensive treatment (ROA 212-3; R. Doc. 95-9 at 4-5).

October 16, Rhodes' committee removed Joshua from PC and authorized his transfer to SRU (ROA 382-3, 476; R. Doc. 110-5 at 7-8; R. Doc 110-19). Later that day, Joshua refused to go to SRU. He told a corrections officer he was "dizzy and not feeling well and was not leaving" (ROA 479; R. Doc. 110-20 at 1). He was given a conduct violation for "disobeying an order" (ROA 479; R. Doc. 110-20). Rhodes was told Joshua's medications were making him sick (ROA 384; R. Doc. 110-5 at 9).

Joshua remained in Ad Seg until his death (ROA 330, 350; R. Doc. 112-1 at 4, 24).

October 21 at 12:40 p.m., Corizon staff did an Ad Seg "round" -- a short check at the cell door but did not assess Joshua's willingness to go to SRU (ROA 460-1; R. Doc. 110-14 at 12-3). The note shows the check lasted less than a minute and states in toto: "Offender denied any mental health concerns or complaints at this time. Appears to be functioning adequately in segregation" (ROA 480a; R. Doc. 110-21).

Later that day, Griffin was informed by the cellmate and another offender that Joshua said he

was going to kill himself (ROA 332, 404, 409-10, 418, 481; R. Doc. 110-7 at 5, 10-11, 19; 110-22; R. Doc. 112-1 at 5). Griffin saw Joshua looked disheveled (ROA 405; R. Doc. 110-7 at 6). Griffin did not make a Suicide Intervention Report or initiate suicide watch (ROA 409; R. Doc. 110-7 at 10).

October 22, around 11 a.m., offenders were "screaming" to officer Gooch that Joshua was "going to kill himself." Gooch called for assistance to remove Joshua from the cell (ROA 334; R. Doc. 112-1 at 8). Griffin heard the radio call and came to Joshua's cell (ROA 406; R. Doc. 110-7 at 7). Griffin described Joshua's voice as sounding "shaky" and "he could have been crying" (ROA 339, 408; R. Doc. 112-1 at 13, 110-7 at 9). At the cell, Griffin yelled that Joshua "didn't say the magic words" (tell officers he was suicidal) (ROA 334; R. Doc. 112-1 at 8; and ROA 407; R. Doc. 110-7 at 8). Officer Gooch told the DOC investigator that if Griffin had not intervened, they would have removed Joshua from his cell (ROA 335; R. Doc. 112-1 at 9).

Griffin admitted Joshua's cellmate and another inmate said Joshua was suicidal (ROA 415, R. Doc. 110-7 at 16). Griffin did not follow up and ask why they believed Joshua was suicidal; he did not make a Suicide Intervention Report or initiate suicide watch (ROA 408-9; R. Doc. 110-7 at 9-10).

England also heard Officer Gooch's call for his assistance on October 22 at Joshua's cell: "his cellmate was telling them that he is suicidal" and "to see if they needed to take him out" (ROA 427, 433; R. Doc. 110-8 at 5,11). England heard the cellmate "yelling that he's suicidal," could see Joshua "had been crying a little bit

…" and that Joshua had "a sad look … worried …". England heard Joshua's voice "breaking up" and realized "he was very upset." "I did see a tear in his eye. He was tearing up" (ROA 427, 429, 431, 436; R. Doc. 110-8 at 5,7,9,14). England spoke to Joshua (ROA 429; R. Doc. 110-8 at 7). When Joshua denied being suicidal "his cellmate was yelling back at us and saying that he was" and said a string had been found in the cell by a prior shift of officers (ROA 427; R. Doc. 110-8 at 5). England had Joshua and his cellmate handcuffed, and the cell searched (ROA 427; R. Doc. 110-8 at 5).

England decided to leave Joshua in the cell; he did not make a Suicide Intervention Report or initiate suicide watch (ROA 430, 434; R. Doc. 110-8 at 8,12). Griffin admitted he could have put Joshua on suicide watch, even if the sergeant disagreed: "if the offender is truly suicidal, that's our number one job priority is safety and security of the offenders" (ROA 408; R. Doc. 110-7 at 9).

Soon after England left Joshua in the cell, he told Rhodes that Joshua had "issues" and was crying (ROA 336, 428; R. Doc. 110-8 at 6, 112-1 at 10). Rhodes told him Joshua had a history of being on suicide watch (ROA 428; R. Doc. 110-8 at 6). England still did not make a Suicide Intervention Report or initiate suicide watch (ROA 434; R. Doc. 110-8 at 12).

England admits he should have but did not pass on to the next shift the information he had about Joshua (ROA 431; R. Doc. 110-8 at 9).

Scallion told Rhodes on October 22 other offenders said Joshua was suicidal and that a noose was in the cell the previous night (ROA 342, 365, 370; R. Doc.

110-4 at 5, 10, 112-1 at 16). Rhodes recalled it was after noon (ROA 385; R. Doc. 110-5 at 10). Rhodes looked at video of the search and did not see a noose (Id.) but admitted the cameras only "go into the wings" so that he could not see everything in the cell (ROA 386, 388; R. Doc. 110-5 at 11,13).

Later that afternoon at a disciplinary hearing, Rhodes found Joshua guilty of disobeying the order to leave Ad Seg for SRU. Rhodes imposed 10 days of disciplinary segregation on Joshua (ROA 479-80; R. Doc. 110-20,21). The result was a complete loss of recreation out of the cell (ROA 475; R. Doc. 110-17 at 10). DOC's Suicide Intervention Procedure was supposed to "take precedence over established segregation procedures" (ROA 291; R. Doc. 100-4 at 9).

None of the Respondents notified Corizon mental health staff Joshua was suicidal on October 21 or 22 (ROA 164, 170-1; R. Doc. 95-8 at 20, 26-7).

At approximately 8:15 p.m. that day, Joshua's cellmate left for recreation. At 9:20 p.m., at the end of recreation, staff found Joshua hanging in the cell by a torn bedsheet from a light fixture (ROA 330-1; R. Doc. 112-1 at 4-5). Video shows no cell check was done between 8:30 and 9:30 p.m. (ROA 487; R. Doc. 110-25 at 2). That violated DOC's Post Orders which mandated security checks of each wing every 30 minutes utilizing the wing checklist (ROA 486-7; R. Doc. 110-25 at 2).

The Death Certificate listed suicide by hanging (ROA 491; R. Doc. 110-26 at 5).

DOC's Office of Inspector General (IG) assigned an investigator who interviewed Respondents, other corrections staffers and inmates. The IG's office prepared an investigation report on Joshua's suicide (ROA 327; R. Doc. 112-1) and a memorandum to Warden Villmer detailing operational deficiencies at FCC (ROA 486; R. Doc. 110-25).

The IG found Respondents Rhodes, England, Griffin, and Scallion violated DOC's written "Suicide Intervention Procedure" by failing to initiate a suicide intervention report for Joshua after they were told by inmates Joshua was suicidal (ROA 350; R. Doc. 112-1 at 24). Warden Villmer agreed and submitted each for discipline, which was imposed (ROA 107-8; R. Doc. 95-1 at 75-7).

The DOC's written "Suicide Intervention Procedure" was part of the Missouri State prison system's Policy and Procedure Manual and had been in effect since 2003. It was promulgated by statutory authority (ROA 284; R.Doc. 100-4 at 2).

It defined "Suicidal Behavior" as "the expression either verbally or behaviorally of intent to do harm to oneself that may result in injury or death" (ROA 286; R. Doc. 100-4 at 4).

The Procedure states "staff should be alert for signs of **potentially suicidal offenders**, which may include:

a. offender engages in or attempts to engage in behavior with potential for self-harm (e.g., … self-mutilation);

b. offender threatens to attempt suicide;

> c. **offender talks about suicide or self-injurious behavior with staff or other offenders**;
>
> d. offender exhibits **markedly sad, tearful behavior** or reduced emotional reactivity;
>
> e. offender makes frequent references to death …".

The Procedure establishes Respondents knew Francisco presented a serious risk of self-harm.

The Procedure directs corrections Staff aware of a potentially suicidal inmate how to respond: staff "**will immediately** initiate a Suicide Intervention Report" and "ensure the offender remains under direct surveillance of a staff member until suicide watch procedures can be initiated" (ROA 287; R. Doc. 100-4 at 5; Add. 27) (emphasis added).

The Procedure instructs corrections: "The offender **will be maintained on full suicide watch** until evaluated by a qualified mental health professional" (ROA 288; R. Doc. 100-4 at 6; Add. 28). The evaluation by a qualified mental health professional "should" be done "within the next working day …" (Id.). Qualified mental health professionals are medical personnel (ROA 285; R. Doc. 100-4 at 3). "The **qualified mental health professional will determine the most appropriate option available for managing the potentially suicidal offender** …" (ROA 290; R. Doc. 100-4 at 8; Add. 29) (emphasis added). The written Procedure establishes Respondents unreasonably responded to Francisco's serious risk of suicide.

Scallion (ROA 367, 375; R. Doc. 110-4 at 7,15); Rhodes (ROA 391-2; R. Doc. 110-5 at 16-7); Griffin (ROA 419, 422; R. Doc. at 20, 23); and England (ROA 438; R. Doc. 110-8 at 16) received annual "Suicide Prevention" training. They were informed that "most people who commit suicide have made direct or indirect statements about their suicidal intentions" (ROA 494; R. Doc. 110-28 at 2). They were trained to:

> **TAKE ALL THREATS SERIOUSLY!**
>
> - Don't ignore threat because you think an inmate is simply acting out.
>
> - It is not the officer's responsibility to decide whether the threat is genuine or "fake" – diagnosis is the duty of the mental health professional.
>
> - Always refer potential suicide threats immediately to the mental health professional for evaluation and determination of the level of suicide risk.

(ROA 498; R. Doc. 110-28 at 6) (emphasis in original).

Respondents were trained that an inmate's first offense, mental illness, past suicide attempt, segregation, additional charges/discipline, requesting PC, and decreased staffing increased the risk of suicide (ROA 177-9, 495-7; R. Doc. 95-8 at 33-5, 110-28 at 3-5). Under this training, Respondents knew Francisco was a serious suicide risk and that their response was inadequate on October 22.

The IG found FCC's "segregation staff only placing an offender on suicide intervention status if he uttered the 'magic words.' According to several assigned staff if an offender does not verbally indicate that he is going to harm himself or another offender then he cannot be placed on suicide intervention status." That finding was amply supported by the testimony of Scallion (ROA 371; R. Doc. 110-4 at 11); Rhodes (ROA 388; R. Doc. 110-5 at 13); England (ROA 435; R. Doc. 110-8 at 13); and Griffin (ROA 406-7; R. Doc. 110-7 at 7-8). The Inspector General found FCC's unwritten practice at FCC violated DOC's written policy (ROA 486; R. Doc. 110-25 at 1), IS 12-4.1 (ROA 284; R. Doc. 100-4). The practice arose from a "culture," as described by Corizon's head of Mental Health at FCC, Lisa Sanderson, whereby corrections (especially "seasoned" staff) assumed anything said by a cellmate, often in segregation, was a lie and the offender had to say the "magic words" (ROA 168-9; R. Doc. 95-8 at 24-5). The "magic words" culture was present at FCC since 2010 (*Id.*). Sanderson testified: "the thing that needs to come down is a change in culture. And I can't do that on my own. The culture of the department of corrections is a huge issue and has been" (*Id.*).

B. Proceedings Below

Petitioners asserted claims for the death of Joshua Francisco because of violations by Respondents of his rights under the Eighth Amendment. In the claims pursuant to 42 U.S.C. § 1983, Petitioners alleged Respondents intentionally interfered with Joshua obtaining adequate mental health care by not heeding the signs he was suicidal and immediately placing him on watch. They also sued Rhodes for increasing

the risk of suicide by imposing 10 days of disciplinary segregation on Joshua for failing to obey the order to leave his segregation cell and move to the specialized mental health portion of the prison, just a few hours before he committed suicide.

Suit was filed in the United States District Court for the Eastern District of Missouri, case number 4:17CV1455 HEA, against Corizon Health, Inc., Corizon, LLC, Tom Villmer, Gregory Rhodes, Kimberly Scallion, Jason England, Michael Griffin, Lisa Sanderson, Moses Ambilichu, Marion McIntyre, Rajendra Gupta, and Does 1-30.

The claims against Corizon Health, Inc., Corizon, LLC, Lisa Sanderson, Moses Ambilichu, Marion McIntyre, and Rajendra Gupta were settled during mediation.

The District Court granted motions for summary judgment filed by all Respondents based on qualified immunity on December 27, 2022.

The District Court selectively cited the evidence most favorable to Respondents to find they did not know of a substantial risk that Francisco would commit suicide (ROA 566; R. Doc. 137 at 14). The court found Respondents reasonably responded to Francisco by conducting their own evaluation of his mental health (*Id.*). The court stated, "medical staff ascertained Francisco should not be placed on suicide watch" (*id.*), however, the record established the last mental health evaluation was before the events of October 22. The District Court did not mention evidence that the IG and warden found Respondents violated the prison Suicide Intervention Procedure.

Appeal was taken to the United States Court of Appeals for the Eighth Circuit, case number 23-1036. Summary judgment was affirmed on July 26, 2024. The court failed to cite or apply the correct standard for reviewing summary judgment. *Francisco*, 108 F.4th at 1077.

The court cited the familiar rules for defeating a qualified immunity defense: "plaintiff must (1) assert a violation of a constitutional or statutory right, (2) that was 'clearly established' at the time of the violation, and (3) that a 'reasonable official would have known that the alleged action indeed violated that right.'" *Id.*

Citing precedent from 2000, the court found: "It is clearly established that the Eighth Amendment's prohibition on cruel and unusual punishment applies to protecting prisoners from deliberate indifference to serious medical needs and that a risk of suicide by an inmate is a serious medical need." *Id*. The court held Petitioners met the first two steps of the qualified immunity inquiry. *Id*.

On the third part, the court stated: "Whether a reasonable official would have known that his actions violated an established right involves both an objective and subjective component. The objective component concerns whether a serious deprivation occurred. The subjective component examines the official's state of mind to determine whether he acted with deliberate indifference." *Id*. (citation omitted).

On the deliberate indifference issue, the court rejected without any discussion of the evidence that Respondents were found by the IG and warden to have violated the State's suicide intervention procedure in

their interaction with Francisco. The court stated: "Regardless of whether any officer failed to follow a written policy, the '[f]ailure to follow written procedures does not constitute *per se* deliberate indifference.'" *Id*. at 1078 (citation omitted).

The court affirmed summary judgment for Respondent officers (none a mental health professional) because they: "performed an investigation" (England); "knew that inmates had falsely claimed that their cellmate was suicidal" (Griffin); "observed a gradual improvement in Francisco's behavior prior to his death" (Scallion); and found the allegation of a noose in the cell in the morning was false and received information about Francisco's "state of mind" (Rhodes). *Id*. at 1078-9.

The Eighth Circuit denied Petitions for Rehearing and Rehearing en banc on September 3, 2024.

REASONS FOR GRANTING THE WRIT

I. THE EIGHTH CIRCUIT'S FAILURE TO CONSIDER EVIDENCE OF VIOLATIONS OF PRISON SUICIDE INTERVENTION PROCEDURES IN A CLAIM FOR DENYING ACCESS TO MENTAL HEALTH CARE CONFLICTS WITH OTHER CIRCUITS AND THE TEACHINGS OF THIS COURT, MERITING REVIEW.

The Eighth Circuit conflicts with decisions of other Circuits holding that the violation of suicide prevention procedure requiring immediate suicide watch for a prisoner expressing suicidality evidences deliberate indifference to serious medical/mental

health needs. The sharp divide on this issue determines the outcome of prison suicide cases under the Eighth Amendment. It also is at-odds with the teachings of this Court. Petitioners' case is an ideal vehicle for resolving the conflict. Petitioners presented and the lower court expressly decided the question presented. It was outcome dispositive.

In rejecting Petitioners' evidence that Respondents were found guilty of failing to implement the Missouri Prisons Suicide Intervention Procedure, the Eighth Circuit cited a 2012 decision for the proposition that "Regardless of whether any officer failed to follow a written policy, the '[f]ailure to follow written procedures does not constitute *per se* deliberate indifference.' " *Francisco*, 108 F.4th at 1078. The court did not address the importance of that evidence to the question whether Respondents were deliberately indifferent to Francisco's serious mental health needs.

The Panel's decision conflicts with the teachings of this Court. In *Brown v. Plata*, 563 U.S. 493 (2011), the Court upheld injunctive relief to reduce overcrowding because the "mental health care provided by California's prisons has fallen short of minimum constitutional requirements and has failed to meet prisoners' basic health needs." *Id*. at 501. To support the finding of an Eighth Amendment violation, the Court relied upon evidence the "prisons failed to implement necessary suicide-prevention procedures …". *Id*. at 506. The Court observed most suicides resulted from "inadequate assessment, treatment, or intervention" and were "most probably foreseeable and/or preventable." *Id*. at 504. And mentally ill prisoners were housed in "administrative segregation" for extended periods

producing a high suicide rate. *Id.* at 503, 519. The Eighth Circuit did not discuss this precedent.

In *Washington v. Harper*, 494 U.S. 210 (1990), the Court upheld prison policies providing administrative due process to mentally ill prisoners facing involuntary administration of psychotropic medication. The Court reasoned that "an inmate's interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals. … Particularly where the patient is mentally disturbed, his own intentions will be difficult to assess and will be changeable in any event." *Id.* at 231. Under the Suicide Intervention Procedures dismissed by the Eighth Circuit, the decision whether Francisco was truly suicidal was to be made by a qualified medical professional, rather than by unqualified corrections staff such as Respondents. It is anomalous to allow Respondents to avoid liability when violating suicide intervention policies while denying treatment, considering the holding in *Washington v. Harper*.

The Panel's Opinion directly conflicts with precedent from other circuits. *Short v. Hartman*, 87 F.4th 593, 613 (4th Cir. 2023), *cert. denied*, 144 S.Ct. 2631 (2024), held

> a violation of a local policy does not by itself violate the Constitution or give rise to a § 1983 claim, it is nevertheless instructive both in determining the seriousness of the risk posed and in determining whether an officer knew of "the excessive risk posed by the official's action or inaction." The Jail established the Prison Policy to create a

> baseline of when a risk of suicide is sufficiently severe such that additional steps must be taken. These judgments can serve as a proxy for when an inmate's medical need is so "obvious that even a lay person would easily recognize" it. This Policy was implemented for a reason; we cannot now cast it aside as entirely irrelevant to the question of whether additional action was necessary, even though the Policy unambiguously provides that it was.

See also Hyatt v. Thomas, 843 F.3d 172, 180 (5th Cir. 2016) ("failure to properly execute a suicide prevention policy may amount to deliberate indifference"), *Harris v. City of Circleville*, 583 F.3d 356, 369 (6th Cir. 2009) (evidence of officers failure to "comply with stated jail policy" sufficient to defeat summary judgment), and *Woodward v. Correctional Med. Services*, 386 F.3d 917, 930 (7th Cir. 2004) ("deliberate indifference to Farver's safety was demonstrated by CMS's condoning of its employees not following policies").

In *Taylor v. Barkes*, 575 U.S. 872 (2015) (per curiam), the Court did not reject evidence of violations of prison suicide intervention procedures to prove officers acted with deliberate indifference by intentionally denying access to mental health care. Eighth Amendment claims were alleged against the prison system's commissioner and the warden for inadequate supervision of medical personnel conducting pre-incarceration suicide screening. *Id.* at 824. Neither the prison commissioner nor warden had any personal contact with the detainee. *Id.* Significantly, the detainee told his wife the night before he would kill

himself, but she failed to tell anyone at the prison. *Id*. at 823. *Taylor* held the prison commissioner and warden were entitled to qualified immunity because no clearly established "right to the proper implementation of adequate suicide prevention protocols" existed in 2004. *Id*. at 825-6. Petitioners claim is not so narrow. They proved the corrections officers who personally dealt with Joshua interfered with his right to adequate medical/mental health treatment by not placing him on suicide watch when they knew he was suicidal. That right has been clearly established in the Eighth Circuit since 2000.

This split of authority matters. Suicide by the incarcerated is a major public issue. The Department of Justice has found that "a combination of recurring policy violations and operational failures contributed to inmate suicides." *See* Evaluation of Issues Surrounding Inmate Deaths in Federal Bureau of Prisons Institutions, U.S. DOJ Report No. 24-041 at p. i (Feb. 2024). "Suicide has been the leading cause of death in jails every year since 2000" and the fifth leading cause of death in prisons. *See* M. Noonan, et al., Mortality in Local Jails and State Prisons, 2000–2013 - Statistical Tables at pp.1, 20 (Aug. 2015).

The Court should grant the Petition to resolve this important issue of law.

II. THE EIGHTH CIRCUIT ERRONEOUSLY DECIDED AN IMPORTANT QUESTION OF FEDERAL LAW IN CONFLICT WITH THIS COURT'S DECISIONS AND OTHER CIRCUITS: WHAT EVIDENCE OF DELIBERATE INDIFFERENCE DEFEATS QUALIFIED IMMUNITY AT SUMMARY JUDGMENT FOR DENYING A SUICIDAL PRISONER ACCESS TO MENTAL HEALTH CARE.

The Eighth Circuit's decision conflicts with this Court's precedent and those of other Circuits. The Petition presents a question of exceptional societal importance: what evidence is required in a claim for deliberate indifference to serious mental health needs of a suicidal prisoner to defeat summary judgment based upon qualified immunity. The Court has never addressed this precise issue.

In *Estelle v. Gamble*, 427 U.S. 97 (1976), the Court held the Eighth Amendment protects against "deliberate indifference to serious medical needs of prisoners. … This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. Regardless of how evidenced, deliberate indifference to a prisoner's serious illness or injury states a cause of action under § 1983." *Id*. at 104-5. "In order to state a cognizable claim, a prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs." *Id*. at 106. The Court found the claim against prison doctors insufficient because failing to order

diagnostic treatment of the prisoner's back injury was a mere "matter for medical judgment." *Id.* at 107.

Farmer v. Brennan, 511 U.S. 825 (1994), elucidated the proof needed for deliberate indifference, in the context of correctional officers' failure to protect a prisoner from harm by another inmate. The Court began its analysis by holding "prison officials must ensure that inmates receive adequate medical care … and must 'take reasonable measures to guarantee the safety of the inmates.'" *Id.* at 832.

To be actionable, first the deprivation of constitutional rights must be "objectively 'sufficiently serious.'3" That is, the prisoner must be at "a substantial risk of serious harm." *Id.* at 834. Second, the prison official must act with "'deliberate indifference' to inmate health or safety." *Id.*

Deliberate indifference is "recklessly disregarding" a "substantial risk of serious harm to the prisoner." *Id.* at 836.

To be liable under the Eighth Amendment, a prison official "knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference." *Id.* at 837.

"Whether a prison official had the requisite knowledge of a substantial risk is a question of fact subject to demonstration in the usual ways, including inference from circumstantial evidence, and a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious." *Id.* at 842 (citation omitted).

Thus, "if an Eighth Amendment plaintiff presents evidence showing that a substantial risk of inmate (suicide) was 'longstanding, pervasive, well-documented, or expressly noted by prison officials in the past, and the circumstances suggest that the defendant-official being sued had been exposed to information concerning the risk about it, then such evidence could be sufficient to permit a trier of fact to find that the defendant-official had actual knowledge of the risk.'" *Id*. at 842-3 (citation omitted).

"[I]t does not matter whether the risk comes from a single source or multiple sources, any more than it matters whether a prisoner faces an excessive risk of (suicide) for reasons personal to him." *Id*. at 843.

Prison officials may avoid liability if they show "they knew the underlying facts but believed (albeit unsoundly) that the risk to which the facts gave rise was insubstantial or nonexistent" or "if they responded reasonably to the risk, even if the harm ultimately was not averted." *Id*. at 844.

Since *Farmer*, this Court has not addressed the evidence needed to prove deliberate indifference to avoid qualified immunity in an Eighth Amendment claim for corrections officers denying or delaying access to medical, much less, mental health care. This is an important issue that arises frequently in the Circuits and has produced a multitude of conflicting approaches.

The Circuits are split on the question of the sufficiency of proof of deliberate indifference to a serious risk of suicide. Compare with the Eighth Circuit's rejection of evidence that Respondents knew

Francisco was previously on suicide watch, were told he was currently suicidal and observed his upset demeanor but left him in his segregation cell and did not inform the next shift, the results in the following cases: *Estate of Clark v. Walker*, 865 F.3d 544 (7th Cir. 2017), *cert. denied*, 583 U.S. 1180 (2018) (summary judgment on qualified immunity denied to intake officer even though detainee did not say he was suicidal where a screening program indicated he might be and he had a prior suicide attempt); *Troutman v. Louisville Metro DOC*, 979 F.3d 472 (6th Cir. 2020) (qualified immunity for classification officer reversed because officer knew of detainee's prior suicide attempt, other risk factors, and was required by policy to obtain medical clearance before moving detainee to the solitary cell where he committed suicide); and *Hyatt v. Thomas*, 843 F.3d 172 (5th Cir. 2016) (officer knew of substantial suicide risk from wife telling officer he was a threat, he had a suicide history, and was depressed even though detainee denied he was suicidal but affirmed qualified immunity because officer's response of placing him in a video monitored cell without a bedsheet and informing next shift of his risk was reasonable). *See also* Annotation, *Civil Liability of Prison or Jail Authorities for Self-Inflicted Injury or Death of Prisoner*, 79 A.L.R.3d 1210 (citing numerous cases).

Under the teaching of *Estelle*, Petitioners' evidence established that Respondents' failure to put Francisco on suicide watch when he manifested a substantial threat of suicide, in words and behavior, was a "sufficiently harmful" interference with his right to immediate mental health care. The officers' indifference to Francisco's serious medical needs offended the "standards of decency" as set out in

Missouri's prison Suicide Intervention Procedure. The decisions of correctional staff not to put Francisco on suicide watch where he could receive immediate care and, in the case of Rhodes, to impose additional punishment on him for his mental illness were not matters of correctional "judgment." Their response to Francisco's serious suicide risk was prohibited by the Suicide Intervention Procedure. Officers were not to make their own uneducated mental health assessment, based on the statements of a mentally ill inmate.

The well-documented prison record showed Francisco was a substantial suicide risk throughout his incarceration and Respondents knew of his mental health history. On October 22 during the count, the officers heard from other offenders Francisco was suicidal. They observed he was upset and crying. They knew, from policy and training, they were required to put him on suicide watch instead of leaving him in Ad Seg with the means to kill himself. Respondents acted unreasonably.

Rhodes knew not to impose additional punishment – disciplinary segregation with the loss of even more privileges – which increased the risk of harm. Punishing an inmate for an illness violates the Eighth Amendment. *Robinson v. California*, 370 U.S. 660, 678 (1962) (Douglas, J., concurring) ("We would forget the teachings of the Eighth Amendment if we allowed sickness to be made a crime and permitted sick people to be punished for being sick. This age of enlightenment cannot tolerate such barbarous action."). *See also Helling v. McKinney*, 509 U.S. 29, 33 (1993) (jailers may not "ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year").

Francisco's denial of suicidality to the officers was not decisive for Respondents. *Farmer* vacated the summary judgment for qualified immunity and remanded because the "District Court may have placed decisive weight on petitioner's failure to notify respondents of a risk of harm. … [T]he failure to give advance notice is not dispositive. Petitioner may establish respondents' awareness by reliance on any relevant evidence." 511 U.S. at 848. Respondents were made aware of Francisco's suicidality by other inmates and were not trained nor were they permitted to make mental health assessments under prison policy.

The Eighth Circuit did not cite to nor apply the standard for viewing this evidence on review of summary judgment of a qualified immunity claim. *Francisco*, 108 F.4th at 1077. It conflicted with the Court's decision in *Tolan v. Cotton*, 572 U.S. 650 (2014). *Tolan* vacated summary judgment in a deliberate indifference case for an officer's use of excessive force because "the Fifth Circuit failed to view the evidence at summary judgment in the light most favorable to Tolan with respect to the central facts of this case. By failing to credit evidence that contradicted some of its key factual conclusions, the court improperly 'weigh[ed] the evidence' and resolved disputed issues in favor of the moving party." *Id*. at 657.

The Eighth Circuit appears to have viewed the evidence in a light most *unfavorable* to Petitioners. For example, the Panel cited Officer Griffin's self-serving opinion that inmates always lie and dismissed as "unreliable" and "false" the statements to

Respondents by the cellmate and other prisoners that Francisco expressed suicidal thoughts just before noon on the day he committed suicide (ROA 334, R. Doc. 112-1 at 8). The evidence conflicted on this key point. The Prison Suicide Prevention Procedure *required* officers ("will immediately") to initiate suicide watch if an offender told an "other offender" he was suicidal (ROA 287, R.Doc. 100-4). The Panel improperly gave conclusive weight to Griffin's assessment of the credibility of the eyewitness inmates statements about Francisco's suicidality, which turned out to be correct. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986) and *U.S. v. Freitag*, 230 F.3d 1019, 1024 (7th Cir. 2000) (error for one witness to comment upon the credibility of another witness because witness credibility is for the jury).

The Eighth Circuit ignored other clear evidence of deliberate indifference. It did not mention evidence that when speaking to Francisco Respondents England and Griffin observed him "crying," "tearing up," "very upset," and his voice "breaking up" (ROA 339, R. Doc. 112-1 at 13; and ROA 427, 429, 431, 436; R. Doc. 110-8 at 5,7,9,14). The Panel did not mention evidence from warden Villmer (ROA 107-8; R. Doc. 95-1 at 75-9) and the Director of Mental Health at the Prison (ROA 164, 168, 171, 187-8; R. Doc. 95-8 at 20, 24, 27, 43-4) that the facts England, Griffin, Rhodes and Scallion knew about Francisco required them to immediately initiate suicide watch on October 22. The Panel did not discuss the opinion of a medical expert (ROA 514-5; R. Doc. 110-29 at 13-4) or a corrections expert (ROA 527; R. Doc. 110-30 at 11) that Rhodes imposing discipline on a mentally ill inmate for his mental illness was improper.

This evidence made the failure of England, Griffin, Scallion and Rhodes to place Francisco on suicide watch and leave him in a segregation cell unreasonable, *Farmer,* 511 U.S. at 844. The Prison Suicide Prevention Procedure provided a bright line for the officers on how to respond to a "potentially suicidal offender." Respondents' failure to comply with the prison Suicide Prevention Procedure exhibited the unreasonableness of their response to Francisco and deliberate indifference to his serious medical needs. Had the panel applied the proper standard of review, it should have found the evidence sufficient to defeat summary judgment.

CONCLUSION

For each of the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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