Safety in the Cell: Municipal Liability for Custodial Suicide

BY: RUTH F. MASTERS
MastersLaw, Oak Park, Illinois

While Jeffrey Epstein's death in custody has captured public interest, the problem of custodial suicide is far from new. What is new, however, is that the suicide rate in the general population has accelerated over approximately the last decade[1] as has the rate of those committing suicide in local custody.[2]

Not only is this acceleration of suicide inside and outside custody a source of heartache to those personally affected, but the increase has implications for public entities responsible for safeguarding those in custody. Suicide is the leading cause of death in local jails[3] and occurs at higher rates than outside custodial settings.[4]

The confluence of the increased suicide rate in the general population with the known increased vulnerability to suicide in custodial settings suggests that municipalities may benefit from re-examining their suicide prevention protocols. This article surveys the law regarding *Monell* policy claims arising from custodial suicide. And while there is no one-policy-fits-all approach, this article discusses the various theories of liability that plaintiffs have pursued and how courts have analyzed those claims.[5]

The Rising Suicide Rate

According to the Centers for Disease Control and Prevention ("CDC"), the age-adjusted suicide rate increased on average by approximately 1% per year from 1999 through 2006 and accelerated to approximately 2% per year from 2006 through 2017.[6] Thus, from 1999 to 2014, the age-adjusted suicide rate in the general population increased from 10.5 to 13.0 per 100,000,[7] and by 2017, the rate had further grown to 14.0 per 100,000.[8] Both males and females in all age groups from 10 to 74 have experienced an increase in suicide rates since 1999.[9] Further, the increase has been more pronounced in rural areas. In 2017, the age-adjusted rate for the most urban counties was 16% higher than the rate in 1999, compared to 53% higher in the most rural counties.[10] Put differently, by 2017, the suicide rate in the most rural counties was 1.8 times greater than in their urban counterparts.[11]

As the non-custodial suicide rate was accelerating, the custodial suicide rate also increased – from 36 per 100,000 jail inmates in 2006 to 50 per 100,000 jail inmates in 2014.[12] Meanwhile, the jail incarceration rate declined from 256 inmates per 100,000 U.S. residents at midyear 2006 to 234 per 100,000 at midyear 2014.[13] Thus, it appears that while fewer people are being jailed, the rate at which those in custody are taking their own lives is growing.

Additionally, as at least one circuit has repeatedly stated, the relevant metric regarding the constitutionality of a suicide detection protocol is the rate of custodial suicide compared to the rate in the area the jail draws from and the rate in other jails, explaining: "'It is not the number of suicides that is a meaningful index of suicide risk and therefore of governmental responsibility, . . . but the suicide rate; . . . and it is not even the rate by itself, but rather the rate relative to the 'background' suicide rate in the relevant free population (the population of the area from which the jail draws its inmates) and to the rate in other jails."[14]

An Overview of the Basis of Liability

Municipal liability has its well-established roots in *Monell v. Department of*

Social Services.[15] *Monell* provides that a municipality may be liable for damages under 42 U.S.C. § 1983 if the unconstitutional act complained of is caused by: (1) an official policy adopted and promulgated by its officers; (2) a governmental practice or custom that, although not officially authorized, is widespread and well settled; or (3) an official with final policy-making authority.[16] A plaintiff seeking to impose liability on a municipality pursuant to § 1983 "must show that the municipal action was taken with the requisite degree of culpability and must demonstrate a direct causal link between the municipal action and the deprivation of federal rights."[17]

In general, municipalities must have policies safeguarding, although not guaranteeing, inmate health.[18] This is because inmates have no ability to obtain their own treatment and must instead rely upon prison authorities to treat their medical needs.[19] Deliberate indifference to serious medical needs violates the Eighth Amendment prohibition against cruel and unusual punishment.[20] Further, the requirement to treat health conditions encompasses psychological treatment for serious mental illnesses.[21]

Relevant to municipalities, the Eighth Amendment protection against deliberate indifference extends to pretrial detainees by operation of the Due Process Clause of the Fourteenth Amendment.[22] Consequently, a municipality may be liable if "institutional policies are themselves deliberately indifferent to the quality of care provided" and cause a plaintiff harm.[23]

"'Deliberate indifference' is a stringent standard of fault, requiring proof that a municipal actor disregarded a known or obvious consequence of his action."[24] "[W]hen city policymakers are on actual or constructive notice that a particular omission in their training program causes city employees to violate citizens' constitutional rights, the city may be deemed deliberately indifferent if the policymakers choose to retain that program."[25]

Failure to Train and Policy Gaps

An overview of case law reveals that claims arising from custodial suicide are extremely fact-dependent, making general principles difficult to discern.

> Specific to custodial suicide, as the Sixth Circuit has explained, public entities have a duty "to recognize, or at least not to ignore, obvious risks of suicide that are foreseeable, and to take reasonable steps to prevent an inmate's suicide '[w]here such a risk is clear.'"

Often, however, allegations fall into two categories of purported deliberate indifference: failure to adequately train on implementation of existing protocols or absence of a particular protocol in an existing policy. Both have at their heart the idea that a municipality should have done something more or better. And that theory of liability, in turn, has its roots in the failure to train case of *City of Canton v. Harris*.[26]

Harris expanded Monell liability beyond the arena of harm affirmatively caused by enforcement of an unconstitutional policy into the realm of liability for an absence of municipal action. As the Supreme Court explained:

> It may seem contrary to common sense to assert that a municipality will actually have a policy of not taking reasonable steps to train its employees. But it may happen that in light of the duties assigned to specific officers or employees the need for more or different training is so obvious, and the inadequacy so likely to result in the violation of constitutional rights, that the policymakers of the city can reasonably be said to have been deliberately indifferent to the need. In that event, the failure to provide proper training may fairly be said to represent a policy for which the city is responsible, and for which the city may be held liable if it actually causes injury.[27]

The Court, however, cautioned against liability based solely upon proof that an injury or accident could have been avoided if an officer had had better or more training sufficient to equip him to avoid the particular injury-causing conduct. "Such a claim could be made about almost any encounter resulting in injury, yet not condemn the adequacy of the program to enable officers to respond properly to the usual and recurring situations with which they must deal."[27]

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The determination of whether a failure to train or to have a specific suicide prevention protocol in place violates constitutional rights is not, however, conducted in isolation. Instead, courts examine alleged training and policy gaps in the context of all aspects of an existing suicide-prevention policy. This is because "it is necessary to understand what the omission means. No government has, or could have, policies about virtually everything that might happen."[30]

Complicating the picture is the fact that there is no magic number of incidents that must occur before municipal liability for a failure to train or the absence of some particular protocol will be found unconstitutional. The Supreme Court has held that, ordinarily, a pattern of similar constitutional violations is necessary to demonstrate that an omission in a policy or training is deliberately indifferent.[31]

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Ruth F. Masters is the principal attorney at MastersLaw, which represents public entities in a wide range of cases, including section 1983 suits. She focuses on appellate litigation as well as working with clients on dispositive motions and pre-trial litigation strategy. In addition to serving government entities, the firm serves corporate clients, individuals, and non-profit institutions.

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Without a pattern, a municipality will have no notice that the omission is causing injury.[32]

The Court, however, has also stated that evidence of a single violation of federal rights could possibly trigger municipal liability if the violation was a "highly predictable consequence" of the municipality's failure to act.[33]

One further note on numbers: several circuits have explicitly rejected a plaintiff's attempt to establish deliberate indifference by relying upon the number of attempted suicides, finding that attempts are not probative of whether a suicide prevention policy is deliberately indifferent.[34]

An Overview of Failure to Train Cases

Failure to train cases have at their core the assertion that a municipality did not do enough to ensure that its policy was being implemented. Most of these claims fail because the plaintiff attempts to establish a widespread policy of deliberate indifference by relying only upon the incident involving their decedent and only upon a failure to train regarding one particular policy aspect. That approach fails to establish both the existence of a policy of not training and that the municipality is on notice that its alleged failure to train is causing a deprivation of detainees' constitutional rights. By contrast, failure to train claims have succeeded where a plaintiff can show such widespread disregard of existing protocols by municipal employees that a policy might as well be non-existent.

For example, in a recent Fifth Circuit case, the plaintiff sued a municipality alleging, among other claims, that the employee tasked with monitoring the jail's camera feed had not been properly trained.[35] The employee failed to notice that the decedent had blocked the camera in his cell.[36] The plaintiff alleged that the employee displayed "utter confusion" about her responsibility to monitor camera feeds.[37]

The court rejected the claim, noting that appellants had no evidence of a pattern of violations stemming from deficient training and could not establish any deficiency based upon the single incident at issue.[38] The record lacked evidence regarding the employee's training (or lack thereof) or "evidence about the population that passes through the City's jail or about the jail's operations from which the possibility of recurring situations threatening to constitutional rights might be assessed."[39]

In another Fifth Circuit case, the court similarly rejected a claim of failure to train due to a lack of evidence beyond the incident at issue. The plaintiff alleged deliberate indifference because of a purported custom of county officials "encourag[ing] the use of lackadaisical procedures when supervising inmates and creating a situation of inability for officers to complete what they must to ensure the protection and safety of inmates in their care."[40]

The decedent stated at his intake process that he intended to kill himself.[41] Pursuant to policy, the decedent was placed on suicide watch, which required a jail guard to check on him every 30 minutes.[42] During roll call, an officer saw the decedent lying on his stomach, but did not observe his face, which was a violation of jail policy.[43] When the officer later returned to the cell, he discovered that the decedent had hung himself.[44]

Among other claims, the plaintiff alleged a failure to train based upon the officer's failure to conduct the policy's required face-to-face observation of an inmate on suicide watch.[45] In support, the estate relied upon three prior suicides spanning a time period of 13 years.[46] The court held that the prior incidents were distinguishable on their facts, too infrequent, and over too long a period of time to be deemed the result of an accepted practice of inadequate training.[47]

One of the few cases finding a deliberately indifferent failure to train is *Woodward v. Correctional Medical Services of Illinois, Inc.* where the plaintiff adduced evidenced of a systemic failure to train on implementation of suicide prevention protocols.[48] The decedent in *Woodward* expressed suicidal thoughts at his intake screening and divulged a history of psychiatric hospitalizations.[49] Despite the policy requirement of a prompt mental health evaluation, none was conducted until seven days later, at which point the inmate again expressed suicidal thoughts.[50] Again contrary to policy, the inmate was not seen by a psychiatrist until another week later, who again noted that the inmate expressed suicidal ideation and placed him on medication.[51] At no point did anyone implement the jail's suicide prevention protocols, and two days after seeing the psychiatrist, the inmate hung himself.[52]

The detainee's estate sued the jail health care provider, Correctional Medical Services of Illinois, Inc. ("CMS"), alleging, among other claims, deliberate indifference in failing to adequately train personnel to implement suicide prevention protocols.[53] The court rejected CMS's argument that it could not be liable because there had been no prior suicides observing, "[t]hat no one in the past committed suicide simply shows that CMS was fortunate, not that it wasn't deliberately indifferent."[54]

Further, the court concluded that CMS's liability was not based on a single instance of flawed conduct. Instead, there was evidence of multiple failures by CMS to ensure its protocols regarding inmate safety were enforced and evidence of CMS condoning employees' disregard of the protocols.[55] This included CMS failing to train employees on its policies and procedures regarding the treatment of mentally ill inmates; permitting employees not to completely fill out intake forms; allowing mental health professionals to not review the intake forms; and condoning employee resistance to putting inmates on suicide watch.[56] The court ultimately found that CMS had essentially ignored its policy, and that ignoring a policy was the same as having none at all.[57]

Somewhat similarly, the Ninth Circuit recently addressed why a *Monell* failure to train claim survived summary judgment although the employee whose actions were at issue was entitled to qualified immunity.[58] There, an employee failed to take away a detainee's belt during processing, which he used to hang himself in his cell.[59] The court noted that an independent audit of the police department concluded that many members had "only a passing knowledge of Department policies."[60] The court explained that a jury could, for instance, find that the detainee suffered a constitutional deprivation as a result of the department's failure to ensure compliance with its policy of removing belts from detainees; or to assure proper monitoring of cell security cameras.[61]

An Overview of Policy Gap Cases

Frequently, courts reject claims based upon alleged policy gaps due to the lack of evidence of deliberate indifference when the alleged gap is viewed in the context of the policy as a whole. They also reject claims based upon a lack of evidence that a municipality had notice its current approach was unsatisfactory and was causing injury. Underlying these outcomes is the principle in *Canton* that municipal liability cannot be established simply by showing that something more or better could have been done to avoid injury in the particular case at issue.

For instance, a number of cases have rejected allegations that a policy is constitutionally inadequate for failing to require that a mental health professional with specifiic credentials conduct suicide screening.[62]

In *Perez v. Oakland County*, the Sixth Circuit rejected a claim of deliberate indifference arising from the county's practice of having non-medical personnel – in this case an inmate caseworker – make housing assignments of mentally ill inmates.[63] The court noted that the plaintiff "provides no evidence that this practice has ever resulted in a suicide or attempted suicide by another inmate, either at the County Jail or in another jail across the country . . . and the lack of statistics to support this conclusion furthers the argument that there was a lack of foreseeability."[64]

The Seventh Circuit rejected a similar claim in *Minix v. Canarecci.* There, the jail had an agreement with Madison Center, Inc., ("Madison") a community mental health center, to provide mental health services.[65] Madison represented to the jail that the person who conducted the decedent's mental health evaluation was a Qualified Mental Health Professional as defined in the Indiana Administrative Code, when she was not. Instead, the employee lacked the necessary master's or doctoral degree in one of the specified disciplines such as psychiatry, psychology, and social work.[66] The employee had completed course work, training, and other experience in fields such as community health, mental illness, and the treatment of prisoner.[67] The court rejected a claim of deliberate indifference against Madison where there was no evidence that the employee's lack of a formal license or specific degree played any role in the decedent's suicide.[68]

The Tenth Circuit in *Ernst v Creek County Public Facilities Authority* similarly rejected a challenge to a policy of allowing licensed professional counselors and licensed professional nurses to conduct suicide-risk assessments.[69] The court held that there is no constitutional requirement that only licensed physicians or psychiatrists conduct suicide evaluations.[70]

Thus, a review of case law shows that to-date, avoiding deliberate indifference does not require that only those with a particular credential conduct an assessment of suicide risk.

Courts have also rejected claims that a policy is deliberately indifferent for failing to require a certain level of care of detainees identified as suicidal.[71] For instance, in *A.H. v. St. Louis County,* St. Louis County Missouri's Jail Suicide Prevention and Response Policy classified potentially suicidal inmates into three levels of oversight that differed on where they were housed, the frequency of observations, and the availability of bedding.[72] The decedent in *A.H.* committed suicide while categorized in the least restrictive protocol, "precautionary status."[73]

Considering the suicide prevention policy as a whole, the court rejected the claim that the county was deliberately indifferent because the precautionary status protocol allowed inmates to be alone in their cells, to have bed sheets, and did not require them to be monitored more than the inmate population at large when in general housing.[74] The court noted that the policy as a whole "detailed extensive procedures for handling potentially suicidal detainees and mandated annual employee training."[75] It concluded that a policy "cannot be both an effort to prevent suicides and, at the same time, deliberately indifferent to suicides."[76]

And in *Lapre v. City of Chicago,* the Seventh Circuit similarly rejected claims that a failure to implement a variety of specific suicide prevention protocols evidenced deliberate indifference.[149] These alleged policy gaps included the failure to remove horizontal bars from lockup cells; the failure to install suicide kits; the failure to reassess for suicide risk detainees who returned to lockup after a court appearance or some other absence; and the failure to conduct in-person cell inspections every 30 minutes, as opposed to requiring checks every 15-mintues and allowing the checks to be made via video-feed.[78]

The court concluded the claims failed because there was no evidence the policy as a whole was deliberately indifferent and/or no evidence of causation linking a purported policy gap to an increased risk of suicide. Although the City was aware that horizontal bars were used to commit suicide, the court found no deliberate indifference noting both that the City built newer lockup facilities without horizontal bars and that the City took other precautionary measures to prevent suicide in its facilities.[79] Further, the plaintiff failed to adduce evidence of causation or notice of any known risk regarding the lack of suicide kits[80] or the failure to reassess detainees upon a return to lockup.[81] The plaintiff also lacked evidence that in-person inspections of any particular frequency would affect the suicide risk for detainees.[82]

By contrast, the Third Circuit in *Simmons v. City of Philadelphia* affirmed a jury verdict in favor of the plaintiff alleging that Philadelphia violated a detainee's constitutional rights by failing to have in place, and train on, suicide screening protocols specific to intoxicated and potentially suicidal individuals.[83] The evidence in that matter showed that intoxicated individuals were far more likely to commit suicide than others.[84]

Simmons, however, is of limited value. The judges in favor of affirming relied upon differing theories regarding the relevancy of a policymaker's state of mind and cost/benefit analysis to deliberate indifference analysis.[85]

Conclusion

In sum, relatively few cases have held that a municipality was deliberately indifferent to its obligation to ward against custodial suicide. But given the increase in suicide in the general population and rising custodial suicide rates, municipalities may be well served by re-assessing their policies and their training to ensure compliance with constitutional standards.

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1. Holly Hedegaard, M.D., Sally C. Curtin, M.A., and Margaret Warner, Ph.D., "Suicide Mortality in the United States, 1999–2017," NCHS Data Brief No. 330, November 2018, available at https://www.cdc.gov/nchs/products/databriefs/db330.htm ("2018 CDC Report").
2. Margaret Noonan, "Mortality in Local Jails, 2000-2014 - Statistical Tables," US DOJ, Office of Justice Programs, Bureau of Justice Statistics (December 2016), available at http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5865. ("BJS 2016 Report").
3. *Id.* The Bureau of Justice Statistics defines "jails" as "correctional facilities that confine persons before or after adjudication and are usually operated by local law enforcement authorities. Jail sentences are usually for 1 year or less. Jails also—receive individuals pending arraignment and hold those awaiting trial, conviction, or sentencing remit probation, parole, and bail-bond violators and absconders temporarily detain juveniles pending transfer to juvenile authorities hold mentally ill persons pending transfer to appropriate mental health facilities hold individuals for the military, for protective custody, for contempt, and for the courts as witnesses release inmates to the community upon completion of sentence transfer inmates to federal, state, or other authorities house inmates for federal, state, or other authorities because of crowding in their facilities sometimes operate community-based programs as alternatives to incarceration." https://www.bjs.gov/index.cfm?ty=tp&tid=12.
4. Lapre v. City of Chicago, 911 F.3d 424, 430 (7th Cir. 2018).
5.This article does not address claims against individual employees.
6. 2018 CDC Report, https://www.cdc.gov/nchs/products/databriefs/db330.htm
7. Sally C. Curtin, M.A., Margaret Warner, Ph.D., and Holly Hedegaard, M.D., M.S.P.H, "Increase in Suicide in the United States, 1999–2014," NCHS Data Brief No. 241, April 2016, available at https://www.cdc.gov/nchs/products/databriefs/db241.htm ("2016 CDC Report").
8. 2018 CDC Report, https://www.cdc.gov/nchs/products/databriefs/db330.htm
9. *Id.*
10. *Id.*
11. *Id.*
12. BJS 2016 Report, Table 4, https://www.bjs.gov/index.cfm?ty=dcdetail&iid=243. 2014 is the last date for which the Bureau of Justice Statistics has published a suicide rate. https://www.bjs.gov/index.cfm?ty=dcdetail&iid=243. For this reason, the comparisons between the rise in suicide in the general population and the custodial population are imprecise.
13. Zhen Zeng, "Jail Inmates in 2017", US DOJ, Office of Justice Programs, Bureau of Justice Statistics (April 2019), Table 1, available at https://www.bjs.gov/content/pub/pdf/ji17.pdf. The rate declined further to 229 per 100,000 at midyear 2017. *Id.*
14. *Lapre*, 911 F.3d at 432, *quoting Boncher ex rel Boncher v. v. Brown County,* 272 F.3d 484, 486-87 (7th Cir. 2001).
15. 436 U.S. 658 (1978).
16. *Id.*
17. Board of County Commissioners of Bryan County v. Brown, 520 U.S. 397, 404 (1997).
18. Estelle v. Gamble, 429 U.S. 97, 103 (1976); *Lapre*, 911 F.3d at 431; Lopez v. LeMaster, 172 F.3d 756, 759 (10th Cir.1999).
19. *Estelle*, 429 U.S. at 103.
20. *Id.* at 104-05.
21. Brown v. Plata, 563 U.S. 493, 503–07 (2011); Bays v. Montmorency County, 874 F.3d 264, 269 (6th Cir. 2017); Cox v. Glanz, 800 F.3d 1231, 1248 (10th Cir. 2015); Minix v. Canarecci, 597 F.3d 824, 831 (7th Cir. 2010); Clark-Murphy v. Foreback, 439 F.3d 280, 292 (6th Cir. 2006) (surveying cases).
22. *E.g., Rouster v. County of Saginaw*, 749 F.3d 437, 446 (6th Cir. 2014), *Minix*, 597 F.3d at 831.
23. Glisson v. Indiana Department of Corrections, 849 F.3d 372, 378 (7th Cir. 2017).
24. *Brown*, 520 U.S. at 410.
25. Connick v. Thompson, 563 U.S. 51, 61 (2011).
26. 489 U.S. 378, 390-92 (1989).
27. *Id.* at 390.
28. *Id.* at 391.
29. Perez v. Oakland County, 466 F.3d 416, 430 (6th Cir. 2006), quoting Gray v. City of Detroit, 399 F.3d 612, 618 (6th Cir. 1992).
30. Calhoun v. Ramsey, 408 F.3d 375, 380 (7th Cir. 2005).
31. *Connick,* 563 U.S. at 62.
32. *Id.*
33. *Brown,* 520 at 409.
34. A.H. v. St. Louis County, i, 891 F.3d 721, 729 (8th Cir. 2018) (stating that, "if anything" statistics on attempted suicide show a policy "was effective in avoiding the unfortunate reality of inmate or detainee suicide."); Pittman v. County of Madison, 746 F.3d 766, 780 (7th Cir. 2014) ("The bare fact that other inmates attempted suicide does not demonstrate that the jail's policies were inadequate, that officials were aware of any suicide risk posed by the policies or that officials failed to take appropriate steps to protect" an inmate who attempted suicide.).
35. Garza v. City of Donna, 922 F.3d 626, 631 (5th Cir. 2019).
36. *Id.*
37. *Id.* at 637.
38. *Id.* at 638.
39. *Id.*
40. Fuentes v. Nueces County, 689 F. App'x 775, 778 (5th Cir. 2017).
41. *Id.* at 776.
42. *Id.*
43. *Id.*
44. *Id.*
45. *Id.* at 778.
46. *Id.*
47. *Id.* at 778-79.
48. 368 F.3d 917 (7th Cir. 2004).
49. *Id.* at 923.
50. *Id.* at 924.
51. *Id.* at 925.
52. *Id.*
53. The court viewed CMS as standing in the place of a government entity because CMS took over the public function of being a jail administrator. *Id.* at 927 n1.
54. *Id.* at 929.
55. *Id.* at 927-29
56. *Id.*
57. *Id.* at 929.
58. Horton by Horton v. City of Santa Maria, 915 F.3d 592 (9th Cir. 2019).
59. *Id.* at 596.
60. *Id.* at 605.
61. *Id.*
62. Perez v. Oakland County, 466 F.3d 416 (6th Cir. 2006), Minix v. Canarecci, 597 F.3d 824 (7th Cir. 2010), Ernst v. Creek County Public Facilities Authority, 697 F. App'x 931 (10th Cir. 2017).
63. *Perez,* 466 F.3d at 420.
64. *Id.* at 431.
65. *Minix*, 597 F.3d at 828.
66. *Id.* at 832
67. *Id.*
68. *Id.* at 832-33.
69. *Ernst*, 697 F. App'x at 934.

70. *Id.*
71. *A.H.*, 891 F.3d at 728–29; Whitney v. City of St. Louis, , 887 F.3d 857, 858–59 (8th Cir. 2018) (alleging deliberate indifference by failing to have a policy of constant surveillance).
72. *A.H.*, 891 F.3d at 725.
73. *Id.*
74. *Id.* at 728.
75. *Id.*
76. *Id.* at 728–29
77. *Lapre*, 911 F.3d at 430.
78. 911 F.3d at 430-31.
79. *Id.* at 432–33.
80. *Id.* at 433-34
81. *Id.* at 434–35
82. *Id.* at 436.
83. Simmons v. City of Philadelphia, 947 F.2d 1042, 1051 (3d Cir. 1991).
84. *Id.*
85. *Id.* at 1089 (Sloviter, J. concurring in the judgment). **ML**

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(a) a United States court of appeals has entered a decision in conflict with the decision of another United States court of appeals on the same important matter; has decided an important federal question in a way that conflicts with a decision by a state court of last resort; or has so far departed from the accepted and usual course of judicial proceedings, or sanctioned such a departure by a lower court, as to call for an exercise of this Court's supervisory power;
(b) a state court of last resort has decided an important federal question in a way that conflicts with the decision of another state court of last resort or of a United States court of appeals;
(c) a state court or a United States court of appeals has decided an important question of federal law that has not been, but should be, settled by this Court, or has decided an important federal question in a way that conflicts with relevant decisions of this Court.

4. *See e.g., Kiesla v. Hughes*, 584 U.S. __ (2018); *White v. Pauly,* 580 U.S. __(2017), 137 S.Ct. 548 (per curiam); *Mullenix v. Luna,* 577 U.S. __ (2015).
5. Salazar-Limon v. Houston, 581 U. S. ___ (2017).
6. *Id.*
7. Martin v. City of Boise, 920 F.3d 584, 603 (9th Cir. 2019) (substituted opinion).
8. Martin v. City of Boise, 920 F.3d 584, 590 (9th Cir. 2019) (Smith., J. dissenting)
9. *See* https://www.cocklelegalbriefs.com/blog/supreme-court/matters-of-practice-dealing-with-potential-vehicle-problems/
10. *Id.* **ML**

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journed with the understanding that the alleged bias would be addressed when the hearing convened. The bias claim was denied, and the Applicant successfully filed a leave to appeal. The Court held that the Board had demonstrated prejudice by expressing annoyance with the Applicant's requests and as a result quashed the Boards decision, ordering the matter to be sent back before the Board and heard by a new panel. The Applicant filed a notice of appeal, which was denied by the case management office as a result of numerous defects, including that it was filed late. The question before the Court was whether it should grant an extension.

HELD: Application dismissed.

DISCUSSION: As per the Rules of Civil Procedure, the Applicant had to file the notice of appeal within 30-days after the decision was issued; if filed thereafter, the Court has the authority to extend the time or strike the appeal. The Applicant's primary argument was that the notice of appeal was timely: the Court's decision was issued on January 30, with the costs portion of the decision issued February 15. The Applicant argued that as per Rule 14.8(1)(b) the one-month time should not have started until the costs portion of the decision was issued. Under this Rule, time runs from the date of the decision, which is the latter of (a) the date of the decision under appeal or (b), if reasons are given later, the date the later reasons are issued.

The Court disagreed, noting that Rule 14.8(1)(b) does not apply because full reasons were already provided, and Rule 14.8(1)(b) is used when a decision is made with reasons "to follow," allowing an applicant to file an appeal after knowing all the reasons to challenge. As a result, the time to file the notice of appeal had expired 30 days after the January 30 issuance date, requiring the Applicant to obtain an extension of time from the Court. The Court determined that the Applicant's appeal proposed no reasonable prospect of success as most of the claims brought forward were moot. The application was dismissed. **ML**