Check for updates

SAGE Open
January-March 2018: 1–11
© The Author(s) 2018
DOI: 10.1177/2158244018754936
journals.sagepub.com/home/sgo
SAGE

On the Death of Sandra Bland: A Case of Anger and Indifference

George C. Klein[1]

Abstract

Trooper Brian Encinia conducted a traffic stop on Ms. Sandra Bland in Prairie View, Texas, on July 10, 2015. Ms. Bland was not cooperative. She swung her fist at him. Trooper Encinia verbally escalated the situation. He arrested her. She struggled with him outside of her vehicle. She was taken into custody and charged with a felony. She was taken to the Waller County Jail. The jail staff ignored both her history of depression and numerous cut marks on her arm. The jail staff did not place her on suicide watch. She could not raise her bail. Ms. Bland rolled a plastic trash can liner into a noose and hung herself in the cell. She was pronounced dead on July 13, 2015. Larger issues concerning de-escalation in police–citizen encounters and jail suicide are also examined.

Keywords

Ms. Sandra Bland, de-escalation, jail suicide, police-citizen encounters

Introduction

This analysis is of the arrest, booking, and suicide of Ms. Sandra Bland. It is a narrow analysis of the actions of a few individuals. More specifically, it is an analysis of the behavior of Ms. Bland, Trooper Brian Encinia, and the staff of the Waller County Jail. The analysis is from criminal justice and mental perspectives.

At the end of the analysis, three larger policy issues will be discussed. These issues are de-escalation in police–citizen encounters, death in custody in the Texas criminal justice system, and mental health services in rural jails.

The Incident

The Traffic Stop[1]

Texas State Trooper Brian Encinia was on a traffic stop in Prairie View, Texas, on July 10, 2015.[2] (Prairie View, Texas, is about 45 miles northwest of Houston.) Encinia's dashboard camera video showed him facing University Drive, near Prairie View A&M University. Ms. Sandra Bland's car approached University Drive, rolled through a stop sign, and turned right to head south. Trooper Encinia followed Ms. Bland south on University Drive with his emergency lights flashing. He accelerated and caught up to Ms. Bland's vehicle. She pulled to the right when Encinia came up behind her.

Trooper Encinia exited his vehicle and approached Ms. Bland's vehicle. He made a passenger side approach. "The reason for your stop is because you failed to signal the lane change," Trooper Encinia said when he first addressed her. He immediately noticed that she was stomping her feet on the floorboards and breathing heavily.

Trooper Encinia then returned to his vehicle. Trooper Encinia had decided to issue Ms. Bland a warning ticket. As he did his paperwork, he stated that she made "numerous furtive movements including disappearing from view." Several minutes later, he completed his paperwork. He then returned to her car. He approached her vehicle on the driver's side.

Trooper Encinia then asked:

Trooper: "You OK?"
Bland: "I'm waiting on you. This is your job. I'm waiting on you. What do you want me to do?"
Trooper: "You seem very irritated."
Bland: "I am. I really am. Because of what I've been stopped and am getting a ticket for. I've been getting out of the way. You've been speeding up, so I move over and you stop me. So yeah, I am a little irritated. But that didn't stop you from giving me a ticket."
Trooper: "Are you done?"
Bland: "You asked me what was wrong and I told you. So now I'm done, yeah."

[1]Oakton Community College, Des Plaines, IL, USA

Corresponding Author:
George C. Klein, Professor Emeritus, Oakton Community College, Des Plaines, IL 60016, USA.
Email: klein@oakton.edu

Creative Commons CC BY: This article is distributed under the terms of the Creative Commons Attribution 4.0 License (http://www.creativecommons.org/licenses/by/4.0/) which permits any use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the SAGE and Open Access pages (https://us.sagepub.com/en-us/nam/open-access-at-sage).

Trooper: "OK, OK."
(Pause)
Trooper: "Do you mind putting out your cigarette, please?"
Bland: "I'm in my car. Why do I have to put out my cigarette?"
Trooper: "Well, you can step out now."
Bland: "I don't have to step on out."
Trooper: "Step out of the car."
(He opens the driver's side door.)
Bland: "No, you don't have the right."
Trooper: "Step out of the car!"
Bland: "You don't have the right to do that."
Trooper: "I do have the right. Now step out or I'll remove you."
Bland: "I am getting removed for failure to signal?"
Trooper: "Step out or I'll remove you. I'm giving you a lawful order. Get out of the car now or I'm going to remove you."
Bland: "I'm calling my lawyer."
Trooper: "I'm going to yank you out of here."
Bland: "OK, you're going to yank me out of the car?"
Trooper: "Get out!"
(He reaches into her car.)
Bland: "Don't touch me!"
Trooper: "Get out of the car!"
Bland: "Don't touch me. I am not under arrest. You don't have the right to touch me."
Trooper: "You are under arrest."
Bland: "I'm under arrest for what?"
(Trooper radios for backup.)
Trooper: "Get out of the car! Get out of the car now!"
Bland: "Am I being apprehended? Did you try to give me a ticket?"
Trooper: "Get out of the car!"
Bland: Why am I being apprehended? You done opened my car door. So you're going to drag me out of my own car?" (Associated Press [AP], 2015a).

Trooper Encinia, in a written report, stated,

> I reached into the car with my left hand and reached for her left wrist . . . Ms. Bland leaned over to the passenger side of the vehicle and pulled her left arm away from me. Ms. Bland stated "I'm calling my lawyer" and "let's do this" and swung at me with the closed fist of her left hand toward my head as I reached for her inside the vehicle. I was able to duck out of the way as she swung at me. Ms. Bland swung at me for what I perceived to be two more times and she continued to pull away from me as I tried to grab her arm and remove her from the vehicle. I radioed for backup during this time as I used my left arm to protect myself. Ms. Bland told me that she was not under arrest and I told her that she was under arrest. I stepped away, pulled my [T]aser and pointed it at Ms. Bland. (Texas Department of Public Safety, Texas Rangers [TDPS, TR], 2017, p. 53)

Trooper: "Get out of the car! I will light you up! Get out!"

Bland: *(Stepping out, holding her phone.)* "Wow. Wow. You're doing all this for a failure to signal?"

Trooper: "Get over there!" (*Directing her to the side of the road.*)

Bland: "Right. Yeah, let's take this to court."

Trooper: "Get off the phone!"

Bland: "I'm off the phone. I'm making a record."

Trooper: "Put the phone down."

(*They are now off-camera.*)

Bland: "Are you feeling good about yourself? Are you feeling good about yourself? For a failure to signal, you're feeling good about yourself."

Trooper: "Turn around. Turn around now! Put your hands behind your back and turn around now!" (AP, 2015a)

The remainder of the confrontation occurred outside of the view of the camera. However, the audio captured what sounded like a scuffle. The trooper's written report stated,

> Ms. Bland was pacing back and forth, yelling at me. Ms. Bland continued to pace and use curse words and swing her arms in the air . . . I chose to . . . allow the situation to de-escalate. I kept my Taser pointed at her and I ordered her to turn around. Ms. Bland finally complied with this order and stated, "Are you fucking kidding me?" Then she turned around and placed her hands behind her back. I holstered my [T]aser and attempted to place her in handcuffs for officer safety. As I attempted to place her in handcuffs, Ms. Bland pulled away from me and was swinging her elbows at me. I placed the handcuffs on Ms. Bland and she attempted to pull them off of her wrists and continued to swing her elbows at me. I walked back to Ms. Bland's car to shut her door and get my clipboard. I did this to allow Ms. Bland to de-escalate her violent gestures.
>
> I saw Prairie View Police Department Officer Goodie arrive . . . I attempted to escort Ms. Bland to Officer Goodie's vehicle . . . Ms. Bland began swinging her elbows at me again and stated that I was trying to break her arm. Ms. Bland twisted the handcuffs and grabbed my right hand and ultimately pinched my right hand in between the handcuffs. At the same time, Ms. Bland kicked me in the shin of my right leg with her foot. As this was happening, I . . . used a controlled take down tactic to place her on the ground. I had my knee on the left side of her back . . . Ms. Bland continued to kick her legs and yell at me and I noticed that my right hand was bleeding from being pinched with the handcuffs. (TDPS, TR, 2017, pp. 53-54)

Jail Intake and Mental Health Screening

Ms. Bland was taken to the Waller County Jail for booking.

There are over a dozen intake forms used by the Waller County Jail to process a new inmate. The first mental health screening form for Ms. Bland was administered by a day shift deputy at approximately 5:32 p.m. The "Yes" box was marked for having been depressed, is currently depressed, or having thoughts of suicide in the last year. A second form labeled "Suicide Assessment" was administered later by a night shift jailer. The same questions were answered with "No" (TDPS, TR, 2017, pp. 9-10).

The Suicide Assessment form for Ms. Bland also asked if she ever attempted suicide and by what method. The answer was, "In 2015, Lost Baby by Taking Pills." (Ms. Bland had attempted suicide after she had lost her baby.) She was also asked if she had any recent losses. She answered, "God Mother Passed in Late 2014."

The form asked if she has any current medical problems. Under this question was typed, "Inmate states she has Epilepsy." The Medical Intake form repeated this information. The form also indicated that Ms. Bland took a medication named, "KEPPRA." Another form asked if she was currently taking any medication. "No" was circled (Commission on Accreditation for Law Enforcement Agencies, 2015).

One form was the "Classification Notice." The form consisted of a series of boxes with yes or no answers. The first box was "Current Offense Assaultive Felony." It is marked "Yes." This led her to be classified as a "Medium Assault/Escape" risk. After being booked, she was placed in a medium security cell. She was alone.

Jail Video

Texas authorities released several hours of video of Ms. Bland during her 3 days in the Waller County Jail. Waller County Judge Trey Duhon stated that "Sandra Bland was alive and well" until she committed suicide by hanging herself in her cell on July 13, 2015 (AP, 2015b).

The Suicide and the Autopsy

Just before 9:00 a.m. on July 13, 2017, the video from the jail showed a female officer approach the cell, peer in, and then asked another officer for assistance. Captain Brian Contrell stated, "The jailer looked through the window and observed Ms. Bland hanging from her privacy partition in her cell. She "was found in a semi-standing position with ligatures surrounding her neck." Ms. Bland was then placed on the floor, and jailers began to perform cardiopulmonary resuscitation (CPR) (Ohlheiser & Philip, 2015). Paramedics were called. She was pronounced dead. She was buried in Lisle, Illinois, on July 25, 2015 (Smith, 2015; TDPS, TR, 2017, pp. 3, 7).

A Waller County official held a news conference on July 23, 2015. He stated that Ms. Bland's death was consistent with a suicide. A trash can liner was found around Ms. Bland's neck at the time of her death. He stated that the liner acted as a ligature and that her death was from asphyxiation (Montgomery & Wines, 2015). The autopsy was carried out by the Harris County–Institute of Forensic Sciences (2015).

Afterward

In January 2016, a grand jury indicted Trooper Encinia. Trooper Encinia was charged with perjury, a Class A misdemeanor. It carried a possible penalty of 1 year in jail and a $4,000 fine. The charge stemmed from the one-page affidavit that he had filed after the arrest of Ms. Bland. The deputy wrote that he removed Ms. Bland from her vehicle to conduct a safe traffic investigation. However, according to the prosecutor, "the grand jury found that statement to be false." The grand jury believed that Trooper Encinia arrested Ms. Bland because he was angry when she would not put out her cigarette. The grand jury declined to indict any of Ms. Bland's jailers in connection with her death. Hours after the indictment, the Department of Public Safety began termination proceedings against Trooper Encinia (Montgomery, 2016; Texas Department of Public Safety, Office of the Inspector General [TDPS, OIG], 2016, in Collister, 2017; TDPS, TR, 2017, p. 63).

Early in March 2016, Officer Encinia was formally fired by the TDPS. Later that month, the former Trooper pled not guilty to a charge of misdemeanor perjury (AP, 2016).

In May 2017, Mr. Encinia reached a plea agreement in the case. The perjury charge was dismissed. The agreement stipulated that he surrender his license as a peace officer, agreed to never pursue a career in law enforcement, and agreed not to seek to expunge his charge (TDPS, TR, 2017, pp. 63-64). Mr. Encinia's lawyer stated that Mr. Encinia had been made a scapegoat in the case. The attorney concluded, "It wasn't Mr. Encinia's fault" (Kaleem & Hennessy-Fiske, 2017).

Rafael Zuniga and Michael Serges were the two Waller County jail officers whom the Grand Jury chose not to indict. This was in spite of their admission that they falsified a jail monitoring log. The log indicated that guards checked on Ms. Bland 1 hr before she was found hanging in her cell. Officer Zuniga admitted that the log was filled out in advance. Officers had not checked Ms. Bland for 2 hr before her hanging. In September 2015, they left the Waller County Sheriff's Office. They were then hired by the Waller Police Department. They began work on the same day that they left the jail. The Waller Police Department was considered to be "a smaller agency with less responsibility." The police chief of Waller, who retired 2 weeks after Ms. Bland's death, said that he did not know anything about the two hirings. The acting police chief did not return phone messages (Merchant, 2016).

In September 2016, the Bland family settled a wrongful death suit for $1.9 million. The settlement contained conditions that sensors would be installed in the jail to ensure detainee checks were made on time. The Sheriff's Office agreed that there would be a nurse or emergency medical

technician in the jail at all times. The county administration also agreed to push for more funding to improve booking, training, and the jail functions through legislation named for Ms. Bland (Hauser, 2016; Lee, 2016).[3]

A criminal justice reform bill was introduced in the Texas Legislature in Ms. Bland's name. Most of the criminal justice reforms were stripped from the bill. The bill was now described as a "mental health and awareness piece of legislation." The bill was unanimously passed by the Texas Senate in May 2017. Sharon Cooper, Ms. Bland's sister, commented, "What the bill does . . . renders Sandy invisible . . . It's frustrating and gut-wrenching" (Workneh, 2017).

After Ms. Bland's death, the Waller County Sheriff appointed an independent commission to investigate the incident. The Sheriff promised an all-access, top-to-bottom, investigation. The commission was headed by Mr. Paul Looney, a prominent local attorney. Several months after the commission began its work, Mr. Looney gave an interview to a reporter. In the interview, he stated, "We're not trying to do an expose . . . It's more in the nature of a consultant report for the sheriff to use as he wants." However, Mr. Looney emphasized that the Sheriff had sole discretion over what to do with the report. "He can read it or not read it," Mr. Looney said. "If he wants to throw the whole thing in the trash can, he can," Mr. Looney concluded (Stanford, 2015).

On April 12, 2016, the commission released its report. On the front page was an abstract. The abstract stated,

> A committee was formed to observe the inner workings of the Sheriff's Office and report on and recommend practices and policies to benefit the Office and the citizens of Waller County. The committee was driven by Sandra Bland's words: "I am going to Texas to make it better."

The key recommendations to improve the functioning of the Waller County Sheriff's Office were

- "The present jail is obsolete," the report stated. One reason for this conclusion was that there were no adequate suicide-preventive cells (p. 8).
- The report noted that deputies performed stressful jobs. Such stress could "explode to the surface at the worst possible times and in the worst possible ways" when interacting with citizens (p. 7). Therefore, deputies should undergo anger management sessions every 18 months. Deputies should also have a complete psychological evaluation every 3 years.
- Commissioners conducted ride-alongs and observed "some members of the department persisted in name-calling and dehumanization towards some suspects" (p. 6).
- Emergency medical technicians (EMT's) should staff the jail 24 hours a day, 7 days a week.
- Suicide prevention measures had been "applied in a less than optimal manner" (p. 2).
- The report concluded: "Deputies do not possess the training or expertise to evaluate the medical and mental health needs of inmates" (Waller County Sheriff's Office, 2016, p. 2).

What is this report missing?

Ms. Sandra Bland's name is only mentioned in the abstract. It is absent from the remainder of the report. Trooper Encinia's name is not mentioned in the report. The report noted that policing is stressful and officers may "explode . . . in the worst possible ways."[4] What the report does not say is that Deputy Encinia "exploded" during the arrest of Ms. Bland. Also, the deputies booking Ms. Bland were untrained in evaluating her potential for suicide. The deputies that handled the booking and custody of Ms. Bland were not named. The report noted that the jail was obsolete, with no suicide prevention cells.

It is likely that the report was written by an attorney. The report was not a criminal investigation. Therefore, one could say that individual culpability was not their focus. Instead, the report examined systematic failures. Or, if one were more cynical, one could say the report was "sanitized."

Analysis

The Traffic Stop

Officer Encinia saw Ms. Bland's vehicle roll through a stop sign and turn right. He immediately sped up to initiate a vehicle stop. That is, the moment Trooper Encinia saw Ms. Bland's car, he began to pursue her. What prompted him to act in this manner? He did not pull her over for rolling through the stop sign because he did not know if the stop sign was on public or private property (TDPS, OIG, 2015, in Collister, 2017). Instead, the traffic stop was initiated for not using a turn signal for a lane change. Her explanation was that she did not use a turn signal because she was trying to quickly pull over so that Trooper Encinia could pass her. Her explanation was perfectly reasonable. So, why did the stop occur? We do not know. However, a reviewer of this article, who is a Texas police officer, commented, "The stop for that violation was lawful although it was 'chicken shit'" (personal communication, 2017).

In Texas, officers only require "reasonable suspicion" to stop a vehicle. Police officers in other jurisdictions in the United States can only stop an individual when they have probable cause to believe that an individual is involved in criminal activity. If an individual is driving a vehicle, then any vehicle code infraction is "breaking the law" and may be used to initiate a stop. Legally, this is a considered a "temporary detention" and allows the officer to investigate the behavior of the individual (Rutledge, 2005). These types of stops are routinely carried out by police officers to "check people out." They are often called, "pretext stops." Did Trooper Encinia stop her for not using a turn signal, or did he conduct a pretext stop? We do not know. Encinia's only

explanation of the traffic stop was that he wanted to check the condition of her vehicle. He had accelerated very rapidly toward Ms. Bland's vehicle. When asked if he had accelerated toward other vehicles that rapidly, he answered, "Yes." However, he was not asked why he had done so in Ms. Bland's case (TDPS, OIG, 2015, in Collister, 2017).

When he stopped Ms. Bland, the Trooper walked up to the passenger side of the vehicle. He visually inspected the inside of the vehicle. He stated, "Nothing was in plain view." He told her that she had failed to signal a proper lane change. He stated that at that time, she showed "aggressive body language and demeanor. It appeared she was not okay" (TDPS, OIG, 2015, in Collister, 2017). He then went back to his vehicle to write her a warning citation. However, after he told Ms. Bland why he had stopped her, he could have immediately said, "I'm just going to write you a warning ticket." This could have reduced Ms. Bland's anxiety and could have defused the situation.

When he stopped Ms. Bland, Trooper Encinia stated that he told her that she had failed to signal a proper lane change. He then went back to his vehicle to write her a warning citation. While doing his paperwork, he stated that he saw Ms. Bland make furtive movements and disappear from view.

After writing the warning ticket, he walked up to the driver's side of Ms. Bland's vehicle. He was then silent for 6 s. He then asked, "You OK?" He stated that he asked this question merely to check her condition (TDPS, OIG, 2015, in Collister, 2017). However, his question was prompted by seeing her agitation. Instead of asking her if she was OK, he could have said, "I'm only issuing you a warning ticket. You can be on your way." This, too, would have defused the situation.

He did not articulate his concerns to her about her furtive movements and disappearing from view after he completed his paperwork. He stated that he felt he could have handled this situation better. He believed this was the case because he had missed some instruction during "traffic week" at the police academy. He also stated that Ms. Bland had been flicking cigarette ashes at him. He stated that he was not trained on how to speak to her concerning this problem (TDPS, OIG, 2015, in Collister, 2017).

When he asked her if she was OK, she said, "I'm waiting on you." He was silent for 20 s. He stated he did this to "view the area, what I could see." Instead of saying, "You're free to go now," Trooper Encinia said, "You seem very irritated." This remark further escalated the situation and Ms. Bland vented her anger at a perceived injustice (TDPS, OIG, 2015, in Collister, 2017). The OIG investigator asked if Trooper Encinia could have de-escalated the situation at that point. The Trooper answered, "Things could have been handled differently."

He then escalated the situation by commenting, "Are you done?" He stated that his intention had not been to be sarcastic. He then was silent for another 4 s. Trooper Encinia was asked whether he should have asked more questions. He responded, "I'm not sure" (TDPS, OIG, 2015, in Collister, 2017).

The investigator had noted that the Trooper had observed Ms. Bland for 30 s without speaking. He then asked if Trooper Encinia had prolonged the traffic stop and had detained Ms. Bland for an unreasonable length of time. Trooper Encinia gave only a vague reply.

When she refused to put out her cigarette, Trooper Encinia suddenly escalated the situation by saying, "Well, you can step out now." Why would he do this? She had not committed a crime. However, a law professor has pointed out that during a traffic stop, an officer may order an individual out of a vehicle, even for a nonarrestable offense, if he is concerned about his safety (Lai et al., 2015).

Trooper Encinia did not articulate a reason why Ms. Bland was under arrest. We can assume that he acted in this manner because he felt his authority was being challenged and he became angry. However, because he had no apparent reason to order her out of her vehicle, his anger was inappropriate. Furthermore, a police officer should always try to be "professional." That is, the officer should be emotionally detached (and not takes an individual's words or actions personally). Or, to put this is everyday terms, it appears that Trooper Encinia acted the way he did because he was a "hothead," and he had "a short fuse."

We know very little about Trooper Encinia's career in law enforcement. He received "competent" ratings in all of the evaluations that were released. Were there higher ratings he could have received? We do not know. However, it is likely that ratings such as "good" or "excellent" were available (see AP, 2015c).

After Ms. Bland refused to exit her vehicle, Trooper Encinia reached into the vehicle. The Trooper reached for her left wrist. She then swung at him with her fist. Trooper Encinia then took his Taser from his belt and stated, "I will light you up." At that moment, Ms. Bland was in her vehicle. Was the threat of the use of a Taser appropriate?

If an individual is noncompliant with an officer's orders, the officer will often say, "If you don't cooperate, I will Tase you" or "Don't make me Tase you." This gives the individual a choice. However, to state "I will light you up!" is, one could say, "unprofessional." It also might be an indication that Trooper Encinia was angry and "out of control."

Ms. Bland then exited the vehicle on her own. She asked Trooper Encinia 6 times why she was under arrest. He did not respond. He moved her to the side of the road. He handcuffed her. She asked him 3 or 4 more times why she was under arrest. He did not respond (TDPS, OIG, 2015, in Collister, 2017).

The Supreme Court has ruled in *Terry v. Ohio* that the police can stop and briefly detain a person for investigative purposed if the officer has a reasonable suspicion supported by *articulable facts* that criminal activity was afoot (Rutledge, 2011). In the Bland case, there was no obvious criminal activity. Also, Trooper Encinia was *strikingly inarticulate.*

In regard to the case of Ms. Bland, the Director of the TDPS stated that officers are responsible for escalations. "It's always the trooper" he said.

> We're accountable for every stop. And the citizen has a right to be objectionable—they can be rude. They can do a lot of things. They can say things, they can do things, and at the end of the day, we have an obligation not to react and be pulled into that. We've got to be professional, above that. (Silver, 2016)

Jail Intake and Mental Health Screening

When Ms. Bland was first interviewed by the booking officers, she was asked: Was she ever depressed, did she feel that way now, and did she have thoughts about killing herself within the last year. She answered, "Yes," to these three questions. She was asked if she had ever attempted suicide. She answered, "Yes." She was also asked if she had recently experienced a loss. She again answered, "Yes." Later, she was asked if she was thinking of killing herself today. She answered, "No." These answers should have put Ms. Bland on suicide watch. Furthermore, the booking officers ignored 30 cut marks on her arm. These are signs of self-injurious behavior. Was she referred to a nurse, mental health professional, or physician for further screening? No. Waller County Jail did not have a nurse on duty Friday night and on the weekend (TDPS, TR, 2017, p. 25; see also Montgomery & Wines, 2015; Saint Louis, 2015; Surviving Edged Weapons, 1988).

Because she had cut marks on her arm, she could have been taken by an officer or paramedics to the emergency room of a local hospital for a psychiatric evaluation. This would have been *prudent*.[5]

After the initial intake, a second check on the inmate's criminal history and mental health background was to be conducted via the computer. The staff stated that the system was down. However, the state of Texas stated that the system was functioning normally (Langford, Busch, & Daniel, 2015).

The intake staff could have filled out an "Inmate Mental Condition Report to Magistrate" form. The completion of this brief form would have brought Ms. Bland before a magistrate within 72 hr. She then could have been sent for a mental health evaluation (University of Texas at Austin School of Law Civil Rights Clinic, 2016). The intake staff ignored Ms. Bland's suicidal statement and cut marks. They never filed a report to bring her before magistrate. Instead, they simply followed the charge from Trooper Encinia and placed her in a "Medium Level Assault/Escape" cell (see Merchant, 2015, p. 12).

Ms. Bland was placed alone in a cell. Four female inmates were in a cell across the hall from her. Sixty percent of the individuals, who commit suicide in jails or prisons, do so in a single-occupancy cell. The Federal Bureau of Prisons has noted that "single-cell status is one of the strongest correlates with suicide" (Stamm, 2017). Because the jail staff appears to have had very little mental health training, they were unaware of this potential danger.

For the intake staff, the booking of Ms. Bland appears to have been *routine*. However, the staff could have put Ms. Bland on suicide watch. Or, they could have sent Ms. Bland to a hospital for an evaluation. A suicide attempt, statements concerning depression, recent loss, cut marks on her arm, and a history of epilepsy should have produced a medical and psychiatric evaluation. The jailers who interacted with Ms. Bland did not believe she was depressed. However, she did frequently cry and ate little or no food while in the jail. These are indications of depression (TDPS, TR, 2017, pp. 15-25; see also Hayes, 2015; PubMed Health, 2015). Lindsay Hayes (2015), an expert on jail suicide, concluded, "The booking officers embraced her [Ms. Bland's] denial of suicidal ideation and ignored everything else."

If Ms. Bland had been placed in a suicide-resistant cell, the possibility of self-injurious behavior would have been greatly diminished. Such a cell has a concrete slab for a bed. This does not allow the inmate to reach the ceiling. The cell door would have had a large Lexan panel to allow for unobstructed viewing of the inmate at all times. Vents and light fixtures would be protrusion-free and covered with screening that had holes that were 1/8 inch wide. The cell would not have a corded telephone. The cell would not contain any hooks or other protrusions. The cell would be equipped with a stainless steel combination sink and toilet with concealed plumbing. A modesty wall would have a sloping top to prevent anchoring a ligature to it (Hayes, 2011; Kimme, 1998, pp. 4-100, 4-103). The Waller County Jail did not have such a cell.

If an inmate is considered to be overtly suicidal, they would be placed in a "glass box" constructed of Lexan panels on all four sides. The inmate would then be dressed in a paper gown or safety smock. Such a smock is constructed of quilted nylon Cordura. It cannot be torn into strips to make a ligature. It is held together by Velcro fasteners (Ferguson Safety Products, 2015). The inmate would then have "continuous and uninterrupted" observation to prevent a suicide (Hayes, 2011b). The Waller County Jail did not have such a suicide prevention cell.

Because suicidal indicators were ignored, Ms. Bland was placed in a cell with a plastic garbage can liner. A plastic garbage can liner can be rolled up and be made into a ligature. This is exactly what Ms. Bland did. One Waller County jail staff member stated that the plastic liners were required. However, a search of Title 37, Part 9 of the Texas Administrative Code by the author produced no such requirement (Office of the Secretary of State of Texas, 2015).

Trash can liners are often available in county lockups. However, there are no trash cans in state prisons. In Texas prisons, the inmates take waste out of their cells and place it in trash cans or hand trash to the staff to throw away (see Langford et al., 2015).

There were 501 deaths in Texas jails between 2009 and 2015. There were 310 deaths from natural causes and 140 as a result of suicide. Of the 140 suicides, 118 were deaths by hanging. The items used in these deaths were linens (70), electrical cords (14), clothes (16), bags, including laundry

and trash bags (8), and other methods, including, ropes, showers, curtains, and unspecified items (32) (Dillon, 2013; Langford, 2015; Langford et al., 2015).

The Texas Commission on Jail Standards (TCJS) is a watchdog agency whose mission, in part, is to prevent jail suicides. However, the Commission employs only 16 persons and has a budget of only $1 million a year. It has four inspectors to oversee Texas's 244 jails. Each jail is to be inspected once a year. However, experts complain that the agency is chronically underfunded and understaffed. They also complain that citations for jails only occur after a tragedy. The Commission also sets training standards. The staffs in many county jails often only take a brief online course for handling mentally ill individuals (Walters & Collier, 2015).

After an earlier jail suicide, Waller County was cited by the Commission for not providing an annual 2 hr of yearly mental health training to its staff. The Commission also criticized the jail for not conducting visual, face to face, observations of inmates by jailers every 60 min (see TCJS, 2015).

In the case of Ms. Bland, the Waller County Jail failed to conduct a visual face-to-face observation every 60 min. If an inmate is suicidal, the Texas Administrative Code requires a face-to-face observation every 30 min (Title 37, Part 9, Chapter 275, Rule 275.1). However, the usually accepted national standard is that such observations of suicidal individuals should be conducted every 15 min.

Overall, mental health appears to have a low priority in Texas jails. A 2004 survey of 139 reporting jails were conducted by the TCJS. The survey found that only 15 had any mental health professionals assigned to their facility. Only seven of the 15 had psychiatrists or psychologists on staff. The remaining eight had limited staffs of licensed vocational nurses and case workers. Therefore, mental health screenings in most Texas jails are performed by correctional officers with little or no training in mental health. A substantial minority of jail administrators rated efforts to deliver mental health services in jails as "fair," "poor," or "deplorable" (Mark Keller cited in Julian, 2004, p. 28; University of Texas at Austin School of Law Civil Rights Clinic, 2016).

A recent Federal report on local jails in the United States indicated that the total number of suicides from 2001 to 2013 was 2,577. California and Texas had the highest number of inmate suicides in their jails. California had 425 during that period, and Texas had 326 (Noonan, Rohloff, & Ginder, 2015, p. 25; see also Dillon, 2013; Meisner & Bowean, 2015).

Conclusions on the Case of Ms. Sandra Bland

Trooper Brian Encinia conducted a traffic stop of Ms. Sandra Bland's vehicle on July 10, 2015, in Prairie View, Texas. Once Trooper Encinia stopped Ms. Bland, he saw nothing that was in "plain view." He noticed that she was upset. He decided to issue her a warning ticket. However, he did not inform her of this fact. He then returned to his vehicle. After completing his paperwork, he returned to Ms. Bland's vehicle. By that time, Ms. Bland had become even more agitated. Trooper Encinia could have ended the encounter by giving her the warning ticket and letting her drive off. It is true that Ms. Bland was aggressive. However, the Trooper further escalated the situation by removing her from the vehicle. The result of this was a brief struggle, Ms. Bland being handcuffed, and Ms. Bland kicking Trooper Encinia in the shin. He charged her with a felony. She was then taken to the Waller County Jail.

At the jail, the booking officers ignored signs of depression, a previous suicide attempt, a recent loss, numerous cut marks on her arm, and her epilepsy. She was not taken to a hospital's emergency room for an evaluation. Nor was she placed on suicide watch. A form to see a magistrate to order a mental health evaluation was not filled out.

While in jail, Ms. Bland was crying and refused to take food at the jail. These are all signs of depression. These went unrecognized by the jail staff. This would indicate a lack of mental health training by the jail staff. Ms. Bland was placed in a cell with a plastic garbage can liner. She rolled up the liner and hung herself. She was pronounced dead on July 13, 2015.

Does Trooper Encinia bear some responsibility for Ms. Bland's death? Was the jail staff indifferent to the mental health of Ms. Bland?[6] The author believes that the answer to these two questions is, yes. Others may disagree.

Discussion: Three Larger Policy Issues

There are three larger policy issues that relate to this case. They are de-escalation in police–citizen encounter, death in custody in the Texas criminal justice system, and mental health services in rural jails.

De-Escalation in Police–Citizen Encounter

One might ask: Why do police sometimes escalate such situations? Although not relevant to this case, the "21-foot rule" is important in modern policing. This rule can be traced back to Dennis Tueller, a police instructor in Salt Lake City, Utah. In 1982, he was asked, "How close should the officer allow someone to get to them before he could use deadly force?" Tueller performed some rudimentary tests and concluded that an armed attacker, who ran toward an officer, could cross 21 feet in 1.5 to 1.7 s and stab the officer in the time it took that officer to draw, aim, and fire their weapon (1.7 s). This became the "21-foot rule." This has been taught to virtually all police officers in recent years (Apuzo, 2015; Force Science Institute, 2005). The teaching of this rule is part of the emphasis in the last several decades on "Officer Safety." Many officers have also seen an explicit police training video, entitled, "Surviving Edged Weapons." In the video, it shows simulations of officers repeatedly being

stabbed by an offender. This occurs if the offender starts his or her attack at 21 feet. In other portions of the video, photographs and films of actual knife assaults are shown to emphasize the lethality of knives and other edged weapons (Surviving Edged Weapons, 1988).

Chuck Wexler, the executive director of the Police Executive Research Forum (PERF), has pointed out that typical police cadets receive about 58 hr of training on how to use a gun and 49 hr on defensive tactics. However, they only spend 16 hr learning de-escalation and crisis intervention techniques. In regard to the 21-foot rule, Wexler has emphasized that if an officer is 21 feet from a suspect, he or she can simply step back. This would give the officer time to assess the situation and to call for backup (Apuzo, 2015).

In Britain, most officers do not carry a gun. When they encounter someone with a knife, they talk, are patient, and use only the necessary force to apprehend the suspect (Apuzo, 2015; PERF, 2015, 2016).

In the 1980s programs were created to reduce the police use of force in the U.S. Crisis Intervention Teams (CIT) were created to deal with the mentally ill. These teams were created after the killing of a mentally ill man in Memphis, Tennessee. Therefore, this approach is often called, "the Memphis model." One former police chief pointed out, "Yelling commands at someone who's agitated and maybe delusional, is not going to help." Therefore, CIT or crisis intervention team training involves officers keeping a distance, coaxing, rather than commanding an individual, and using a quiet, conversational tone of voice. The use of de-escalation, CIT, or crisis intervention techniques, may reduce police shootings. It is estimated that 25% to 50% of all the people shot and killed in the United States by the police were mentally ill. It is believed that many of these persons were suicidal. That is why such shootings are called, "suicide by cop" (Klein, 2006; Lord, 2004; Mohandie, Meloy, & Collins, 2009; Perez-Pena, 2016).

In 2015, Chuck Wexler, of the PERF, led a trip for police administrators to Scotland. In Scotland, 98% of the police do not carry guns. The Scottish officers carry radios, batons, handcuffs, and pepper spray. They also carry clear plastic shields in the trunks of their squad cars. They use verbal de-escalation to handle most incidents. In Scotland, the officers use "banter," instead of force. In dealing with individuals with knives or other edged weapons, the officers call for backup, keep their distance, and keep their squad car between themselves and the offender. They talk to the person until backup officers can respond. Those officers then trap or knock down the individual by using their shields. Although officers may "take punches," the last officer killed by criminal violence in Scotland was in 1994. Even armed officers are reticent to use their weapons. The term, "deadly force," is rarely mentioned. These armed response teams have only shot civilians twice in the last decade (Baker, 2015a, 2015b; PERF, 2015, 2016).

Verbal de-escalation, which is drawn from hostage negotiation, is central to avoiding the use of force (see Strentz, 2006). Some of the key principles of de-escalation are:

1. Approach the individual in a nonthreatening manner.
2. Give the individual time to *vent, explain*, or *complain*.
3. *Attempt to establish trust*. Techniques that can be used are:

    a. Be empathic towards the individual.
    b. Act as a neutral third party.
    c. Accept them as they are at the moment.
    d. Assume the person is in crisis.

4. Focus on the problem at hand.
5. Ask about their medications.
6. Begin to give the person *options*.
7. Try to bring the situation to a conclusion (Baker, 2015a, 2015b; Woody, 2005).

In such situations, taking an individual to jail is not always the best option. Depending on their condition and the situation, letting them go, taking them home, or taking them to a hospital emergency room is often a better option.

Death in Custody in the Texas Criminal Justice System

From 2005 to 2015, 6,913 people died in the custody of law enforcement agencies in Texas. High bails have kept tens of thousands of individuals in Texas jails for excessive periods of time (see Schmadeke, 2016).

The three top causes of death while in custody were natural causes (70%), suicide (11%), and justifiable homicide (8%). Of the 1,111 deaths in jails, 41% of these individuals appeared to have been intoxicated, mentally ill, or had medical problems upon entry into the facility. Natural causes accounted for 90% of deaths in prison from 2005 to 2015. However, the leading cause of death in prison for individuals under the age of 35 was suicide (Noonan et al., 2015; Woog, 2016).

Mental Health Services in Rural Jails

The usually accepted rate of mental illness for prisoners in jails ranges from 8% to 16%. However, one report concluded that more than half of all prison and jail inmates had a mental health problem (James & Glaze, 2006). Most state hospitals in the United States were closed in the last 50 years. This was the product of the idea that patients should be "deinstitutionalized." That is, individuals should be free to live in the community unless they were acutely ill. Deinstitutionalization of the mentally ill appears to be the main cause for such a high number of the mentally ill in jails. Other factors contributing to the mentally ill in jail are, a lack of mental health and drug

treatment programs, restrictive commitment laws, the fragmentation of the mental health treatment system, the war on drugs, a lack of psychiatric beds, premature release of the mentally ill from hospital emergency rooms, and a lack of transportation for individuals to access services (Klein, 2009; Race, Yousefian, Lambert, & Hartley, 2010).

The community mental health system is made up of disparate, and often autonomous, programs. These include inpatient hospitalization, outpatient services, supportive housing, support groups, and assertive community treatment. In urban areas, these services can be accessed. However, in rural areas, many of these services do not exist. Also, a lack of transportation services, shortages of mental health professionals, inadequate insurance coverage, and stigma create further barriers to treatment (Race et al., 2010).

When services fail or do not exist, jails often become the de facto mental health treatment center (Klein, 2009; Race et al., 2010).

Some rural jails contract with local community mental health centers for treatment. However, more than 1,500 rural counties in the United States lack a psychiatrist, psychologist, or psychiatric social worker. Most jails, both urban and rural, lack prerelease planning for the mentally ill. Prerelease planning is important because it allows for uninterrupted mental health care, and such care can reduce future incarcerations. Insurance, particularly Medicaid, is often crucial in receiving these services. However, Medicaid is terminated once an individual is incarcerated. Once the individual is released, they must negotiate a lengthy reapplication process (Council of State Governments, 2007).

To gage the severity of this problem, research was conducted in Minnesota, Montana, Texas, Vermont, and Nebraska. Most of the facilities that were studied were small, rural, county-based jails. The researchers found that jail officials estimated that 20% to 55% of the inmates in these jails were mentally ill. Most jail administrators believed that a lack of local mental health resources led to such high incarceration rates for the mentally ill. Most of the administrators felt that these individuals were in jail because there was nowhere else to put them. In jail they received medication. However, upon release, few community services were available. As a result of this, these individuals relapsed. They were soon arrested again. This became a recurring cycle. These inmates were called "frequent fliers" by the jail staff (Klein, 2009; Nebraska Justice Mental Health Institute–Needs Assessment, 2008; Race et al., 2010; Walsh, n.d.).

Another chronic problem in jails is a lack of training for the staff in the screening, handling, and the housing of mentally ill prisoners. Even if a mentally ill individual is identified, it is often difficult to find an appropriate area of the jail in which to house them. One jail official commented, "OK, I have followed the protocol; this person has a mental illness and is acting out, *where do I take him*?" (Race et al., 2010, p. 9, emphasis in the original).

The cause of many of these problems is due to a lack of funding for mental health services in rural jails. However, increased funding for such services is a low priority for most local officials (Race et al., 2010). To put it in other words, jail services are the result of the (political) whims of the local funding body.

This lack of screening, treatment, and services has led to high rates of suicides in jails. The rate of suicide increased in the United States from 10.5 to 13.0 per 100,000 from 1999 to 2014. However, from 2000 to 2007, the average annual suicide rate in jails was 42 per 100,000. By 2013, the rate had increased to 46 per 100,000. However, in small jails, with fewer than 50 inmates, the rate was 169 per 100,000 (Curtin, Warner, & Hedegaard, 2016; Noonan, 2010; Noonan et al., 2015).

Therefore, a lack of training, a lack of services, and a lack of funding, has led to high rates of suicide in rural jails.

Conclusion

In literature, a drama is often the product of an individual's fatal flaw. In the traffic stop of Ms. Bland, both she and Trooper Encinia each possessed such a flaw. This flaw was anger. The result of this was an arrest. Her subsequent death was a result of other flaws. However, the remainder of the drama was not the product of an individual flaw. Rather, it was the product of *institutional flaws.* The jailers at Waller County Jail had received little mental health training. The jail appears not to have had a nurse on duty during the evenings and weekends. The jail did not have any suicide prevention cells. However, similar inadequacies are common in many jails. As a result of this, the suicide of prisoners in U.S. jails occurs at a relatively high rate. However, this is not strictly a "jail problem." Rather, it is the result of the collapse of the mental health system in the United States. However, jails are ill prepared to cope with the mentally ill. These inadequacies in the jails have produced suicide rates 3.5 to 13 times that of the general public. The response of the public, and those who fund the jails, has been indifference.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Notes

1. The Associated Press (2015a) published an edited transcript of Trooper Encinia's verbal exchange with Ms. Bland. This transcript is useful, but incomplete. Information that is not included in the transcript is provided by an investigation of the incident by the TDPS, TR (2017). Information was also taken

from two interviews conducted by an investigator from the TDPS, OIG (2015, 2016; in Collister, 2017; see also Ohlheiser & Philip, 2015; Weidner, 2015; Zorn, 2015).
2. The incident was captured on Deputy Encinia's patrol car's dashboard camera. The tape of the incident is 52-min long.
3. The American Correctional Association (2016) accredits jails in the United States. Sixteen "adult local correctional facilities" in Texas were accredited. No "small jails" in Texas, including Waller County Jail, were accredited in 2016.
4. The dictionary definition of "explode" is that a person's feelings "burst out" and "show sudden violent emotion" (Ehrlich, Flexner, Carruth, & Hawkins, 1980).
5. The dictionary definition of prudent is "showing carefulness and foresight" (Ehrlich et al., 1980).
6. The dictionary definition of indifferent is "feeling or showing no interest or sympathy, unconcerned" (Ehrlich et al., 1980).

References

American Correctional Association. (2016). *Accredited facilities directory*. Alexandria, VA: Author.

Apuzo, M. (2015, May 5). Police rethinking long tradition on using force. *The New York Times*, p.1.

Associated Press. (2015a, July 23). Bland: "You don't have the right to do that." *Chicago Tribune*, p. 10.

Associated Press. (2015b, July 29). Jail video shows bland alive. *Chicago Tribune*, p. 9.

Associated Press. (2015c, August 1). Texas trooper under review was once warned about conduct. *SFGate*. Available from Sfgate.com

Associated Press. (2016, March 22). Ex-Texas cop charged in Sandra Bland's death in court. *New York Daily News*. Retrieved from www.nydailynews.com/news

Baker, A. (2015a, December 11). On patrol Scottish officers rely on an important tool: Banter. *The New York Times*. Retrieved from https://nytimes/1IU7B25

Baker, A. (2015b, December 12). A trip abroad to study policing without guns. *The New York Times*, p. 1. Retrieved from https://nyti.ms/1ITDUhw

Collister, B. (2017, September 19). Trooper fired for Sandra Bland arrest: "My safety was in jeopardy. *Kxan.com*. Retrieved from https://kxan.com/author/brian-collister

Commission on Accreditation for Law Enforcement Agencies. (2015). *Responding to epilepsy and seizure incidents—A guide for law enforcement personnel*. Author. Available from http://www.calea.org/

Council of State Governments. (2007). *How and why Medicaid matters for people with serious mental illness released from nail*. Lexington, KY: Council of State Governments.

Curtin, S., Warner, M., & Hedegaard, H. (2016). *Increase in suicide in the United States, 1999-2014*. Hyattsville, MD: National Center for Health Statistics.

Dillon, D. (2013). A portrait of suicides in Texas jails. *LBJ Journal of Public Affairs*, *21*, 51-67.

Ehrlich, E., Flexner, S., Carruth, G., & Hawkins, J. (1980). *Oxford American dictionary*. New York, NY: Avon.

Ferguson Safety Products. (2015). *Safety smock*. Available from preventsuicide.org

Force Science Institute. (2005, April 22). Is the 21 foot rule still valid when dealing with an edged weapon? Part 1. *Force Science News*, p. 17.

Harris County–Institute of Forensic Sciences. (2015, July 14). *AUTOPSY REPORT, Case No. OC 15-030. ON THE BODY OF: Sandra Annette Bland*. Houston, TX: Harris County–Institute of Forensic Sciences.

Hauser, C. (2016, September 16). Sandra Bland's family settles $1.9 million civil suit, lawyer says. *The New York Times*. Retrieved from https://nyti.ms/2cHKLnp

Hayes, L. (2011a). Checklist for the "suicide resistant" design of correctional facilities. *Ncia.net*. Available from www.ncianet.org

Hayes, L. (2011b). Guide to developing and devising suicide prevention protocols within jails and prisons. *Ncia.org*. Available from www.ncianet.org

Hayes, L. (2015, July 30). The preventable death of Sandra Bland: Lessons learned. *Ncia.org*. Available from www.ncianet.org

James, D., & Glaze, L. (2006, December, 14). *Mental health problems of prison and jail inmates*. Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice.

Julian, T. (2004). *House Bill 1660 Report to the Texas Legislature*. Austin: Texas Commission on Jail Standards.

Kaleem, J., & Hennessy-Fiske, M. (2017, June 29). Charge dropped against deputy in Sandra Bland case. *Chicago Tribune*, p. 10.

Kimme, D. (1998). *Jail design guide*. Washington, DC: National Institute of Corrections, U.S. Department of Justice.

Klein, G. (2006). You can not negotiate everything: Or, "the times they are a changin'." *Journal of Police Crisis Negotiations*, *6*, 17-49.

Klein, G. (2009). *Law and the disordered*. Lanham, MD: University Press of America.

Lai, K., Park, H., Buchanan, L., & Andrews, W. (2015, July 22). Assessing the legality of Sandra Bland's arrest. *The New York Times*. Retrieved from www.nytimes.com/interactive

Langford, T. (2015, July 30). Mental health jail check failed in Bland case. *The Texas Tribune*.

Langford, T., Busch, M., & Daniel, A. (2015, July 24). In Texas jails, hanging most common suicide method. *Texas Tribune*. Available from www.texastribune.org

Lee, W. (2016, September 15). Sandra Bland's family hopes $1.9 M settlement results in jail reform Nationwide. *Chicago Tribune*. Available from www.chicagotribune.com

Lord, V. (2004). *Suicide by cop*. Flushing, NY: Looseleaf Law.

Meisner, J., & Bowean, L. (2015, July 26). Case puts new focus on jail safeguards. *Chicago Tribune*, p. 4.

Merchant, N. (2015, July 25). Jail death focuses new attention on suicides. *The Columbian*, p. 12.

Merchant, N. (2016, August 8). 2 jailers moved into cop jobs after Bland's death. *Chicago Tribune*, p. 12.

Mohandie, K., Meloy, J., & Collins, P. (2009). Suicide by cop among officer-involved shooting cases. *Journal of Forensic Sciences*, *54*, 456-462.

Montgomery, D. (2016, January 7). Texas trooper is charged with perjury in jail death. *The New York Times*, p. 10.

Montgomery, D., & Wines, M. (2015, July 24). Texas autopsy is said to point toward suicide. *The New York Times*, p. 1.

Nebraska Justice Mental Health Institute–Needs Assessment. (2008). Lincoln: Public Policy Center, University of Nebraska.

Noonan, M. (2010). *Mortality in local jails, 2000-2007*. Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice.

Noonan, M., Rohloff, H., & Ginder, S. (2015). *Mortality in local jails and state prisons, 2000-2013—Statistical tables*. Washington, DC: Bureau of Justice Statistics, U.S. Department of Justice.

Office of the Secretary of State of Texas. (2015). *Title 37–Public Safety and Corrections, Part 9–Texas Commission on Jail Standards, Chapters 251 –301*. Available from www.sos.state.tx.us

Ohlheiser, A., & Philip, A. (2015 July, 21). "I will light you up": Texas officer threatened Sandra Bland with Taser during traffic stop. *The Washington Post*. Available from www.washingtonpost.com

Perez-Pena, R. (2016, September 30). When "yelling commands" is the wrong police response. *The New York Times*, p. 12.

Police Executive Research Forum. (2015). *Re-engineering training on police use of force*. Washington, DC: Author.

Police Executive Research Forum. (2016). *Guiding principles on use of force*. Washington, DC: Author.

PubMed Health. (2015). *Levetiracetam (Elepsia, Keppra)*. Washington, DC: National Library of Medicine, National Institute of Health.

Race, M., Yousefian, A., Lambert, D., & Hartley, D. (2010). *Mental health services in rural jails*. Portland, ME: Muskie School of Public Service, University of Southern Maine.

Rutledge, D. (2005, September). Investigative traffic stops. *POLICE Magazine*. Available from www.policemag.com

Rutledge, D. (2011, June). Probable cause and reasonable suspicion. *POLICE Magazine*. Available from www.policemag.com

Saint Louis, C. (2015, July 28). Experts say Sandra Bland's toxicology report raises questions. *The New York Times*. Available from www.nytimes.com

Schmadeke, S. (2016, November 16). Some officials call cash bail unfair. *Chicago Tribune*, p. 6.

Silver, J. (2016, January 19). DPS director: Sandra Bland escalation trooper's fault. *The Texas Tribune*. Available from www.texastribune.org

Smith, M. (2015, July 26). Mourning an "amazing life" cut short in Texas. *The New York Times*, p. 18.

Stamm, A. (2017, March 21). *The problem of Texas jail suicides, and five steps to stop them*. Available from Texascivilrightsproject.org

Stanford, J. (2015, September 24). The Sandra Bland investigation is in trouble. *The Huffington Post*. Available from huffingtonpost.com.

Strentz, T. (2006). *Psychological aspects of crisis negotiation*. Boca Raton, FL: CRC Press.

Surviving Edged Weapons. (1988). *Dennis Anderson, producer and director*. Northbrook, IL: Calibre Press.

Texas Commission on Jail Standards. (2015). Austin, TX: Special Inspection Report.

Texas Department of Public Safety, Office of the Inspector General. (2015, October 8). Brian Encinia audio interview after Bland death (81 minutes).

Texas Department of Public Safety, Office of the Inspector General. (2016, February 22). Brian Encinia interview after indictment (24 minutes).

Texas Department of Public Safety, Texas Rangers. (2017, July 5). Questionable death, Waller county, Hempstead, Victim Bland, Sandra (B/F) (Report of Investigation). Austin, TX.

University of Texas at Austin School of Law Civil Right Clinic. (2016). Preventable Tragedies, Austin, TX.

Waller County Sheriff's Office. (2016). *Recommended police and jail practices*. Waller County, TX: Paul Looney.

Walsh, N. (n.d.). *Reducing mental illness in rural jails*. Washington, DC: National Association of Counties.

Walters, E., & Collier, K. (2015, July 24). Sandra Bland case shows deficiencies in jail oversight. *The Texas Tribune*. Available from texastribune.com

Weidner, R. (2015, July 21). New: Texas DPS trooper says Sandra Bland swung her elbows and kicked him in the shin. *Twitter*. Available from twitter.com.

Woody, M. (2005, Summer). The act of de-escalation. *The Journal*, pp. 56-61.

Woog, A. (2016). *The Texas custody death report*. Austin: Texas Justice Initiative, University of Texas at Austin.

Workneh, L. (2017, May 15). "Gut-wrenching" revisions were made to "Sandra Bland Act," sister says. *The Huffington Post*. Available from huffingtonpost.com

Zorn, E. (2015, July 26). Why, yes, Sandra Bland was "irritated." *Chicago Tribune*, p. 16.

Author Biography

George C. Klein, PhD, is a professor emeritus at Oakton Community College in Des Plaines, IL. He was a part-time police officer for over eight years. He was a consultant and researcher for the Behavioral Science Unit at the FBI Academy for over thirteen years. He is a trained hostage negotiator and worked with a SWAT team. He serves as an expert witness in mental health and criminal justice cases. He is the author of *The Adventure* (2007), *Law and the Disordered* (2009), and *The Militarization of the Police* (in press).