JAIL SUICIDE/MENTAL HEALTH UPDATE

(A joint project of the National Center on Institutions and Alternatives and the National Institute of Corrections, U.S. Department of Justice)

Fall 2003 **Volume 12 • Number 3**

SUICIDE PREVENTION AND "PROTRUSION-FREE" DESIGN OF CORRECTIONAL FACILITIES

On September 10, 1995, a 29-year-old inmate (name unknown) was found hanging from a sheet tied to a clothing hook in his cell at the Nassau County Correctional Center in East Meadow, Long Island, New York. A subsequent state investigative report of the suicide found that the "ligature was tethered to a coat hook. The coat hooks are standard equipment in the cells and are considered suicide resistant due to their collapsible design. The decedent managed to circumvent this feature by threading the sheet behind the hook onto the bolt that supports it." Five years later on January 6, 2000, 40-year-old Lorecia Cox was found hanging from a shoelace tied to a similar clothing hook in her cell at the Nassau County Correctional Center. Following her death, there allegedly were discussions amongst correctional and mental health officials regarding the viability of removing the dangerous clothing hooks throughout the facility. In the end, the hooks remained.

James Gunther, 45-years-old and a New York City police officer, entered the Nassau County Correctional Center on July 11, 2000. He had been charged with criminal contempt for violating a protective order. Mr. Gunther had a history of suicidal behavior and suffered from major depression. He had been hospitalized on four previous occasions. As a result, Mr. Gunther was assigned to the facility's mental health housing unit. On July 31, he attempted suicide and was again psychiatrically hospitalized. On August 15, Mr. Gunther was transferred back to the Nassau County Correctional Center and reassigned to the same housing unit. He was periodically assessed by mental health personnel. One month later on September 15, 2000, James Gunther was found hanging from a sheet tied to a clothing hook in his cell. He was transported to a local hospital and later pronounced dead.

Although advertised to the correctional industry as "suicide-proof" and "collapsible," these clothing hooks are neither. As demonstrated by the Nassau County Correctional Center incidents, suicidal inmates have been known to weave a piece of cloth or shoelace through the back of the hook and attach the ligature to the side supports of the bracket. The hook can also be jammed, thus preventing its collapse and allowing the suicidal inmate to attached the ligature to the hook itself. Following James Gunther's death, clothing hooks were finally removed from *all* cells within the Nassau County Correctional Center.

In late October 2003, a trial commenced in federal court on Long Island involving a lawsuit the Gunther family had filed against several Nassau County defendants. Among issues contested was the allegation that, despite his known risk to commit suicide, the defendants continued to house James Gunther in a cell containing a clothing hook which had previously been utilized as an anchoring device in two other inmate suicides at the facility. On November 4, following three days of testimony, the parties agreed to settle the lawsuit for $875,000.

In early 1998, Jim Spinden, Washington County Sheriff in Hillsboro, Oregon, was taking a tour of his new county jail that was scheduled to open in April. During the tour, Sheriff Spinden noticed that there was an approximate quarter-inch gap between the horizontal security bars and the window glass in each cell. The sheriff theorized that an inmate could either hide contraband within the space, or weave a piece of cloth through the back of the security bar and then attach the ligature for use as an anchoring device in a suicide attempt. The Sheriff's concerns were subsequently discussed amongst members of the jail transition team, contractors, and architects. The sheriff suggested that the security bars should either be moved flush with the glass window or relocated on the outside of the building. The architects apparently responded by stating that placing the bars directly on the glass would be dangerous because an inmate might be able to hit the bars hard enough to shattered the glass. Placement of the bars on the outside of the building, they said, would not be "aesthetically" pleasing to the general public. The option of filling the gap with caulking or glazing tape was discussed but, in the end, the gap in each cell remained and the jail opened on schedule in April 1998.

On August 27, 1998, a mere five months after its opening, the Washington County Jail sustained its first serious suicide attempt.

INSIDE. . .

- Suicide Prevention and "Protrusion-Free" Design of Correctional Facilities
- *Woodward v. Myres, et. al.*: A Favorable Court Ruling and Large Jury Verdict for the Plaintiff
- *On Your Watch: The Challenge of Jail Suicide*
- Jail Mental Health Services Initiative from the National Institute of Corrections (Jails Division)
- News From Around the Country

A correctional officer conducting security rounds found a female inmate lying unresponsive on the bunk with one end of a bed sheet tied around her neck and the other end secured to the horizontal security bar in the cell. The inmate was subsequently transported to the local hospital and treated for her injuries.

Paul Lyche, 35-years-old, entered the Washington County Jail on January 14, 1999. Charged with several counts of sexual abuse, Mr. Lyche had documented histories of both mental illness and suicidal behavior. He was originally classified as a medium-security inmate, but placed under protective custody status after reporting threats from other inmates. On March 29, 1999, Mr. Lyche was found hanging from a sheet that had been

tied to the horizontal security bar in his cell. He was transported to a local hospital and later pronounced dead.

Less than two months later on May 14, 1999, 33-year-old Christopher Wolfram committed suicide in the Washington County Jail. He had also been found hanging from a sheet tied to the horizontal security bar in his cell. Following Mr. Wolfram's death, Sheriff Spinden gathered his management staff together to determine the most efficient way of closing the dangerous gap between the security bar and window glass. "I told them I'm kind of excited about getting going on this," he told *The Oregonian* the day after Mr. Wolfram's suicide. "This is two in a year, and that's unacceptable." Caulking or glazing tape was eventually placed between the bar and glass in all of the cells. A federal lawsuit filed by the Lyche family against the county, health services provider, architects, and other defendants remains pending in Portland, Oregon.

A critical component of any correctional facility's (i.e., jail, prison, juvenile institution, and police department lockup) suicide prevention program should be the safe housing of suicidal inmates. While considerable energy is often devoted to the areas of staff training, identification, assessment, and observation, less thought is given to the physical plant environment. Inmates placed on suicide precautions are frequently housed in un-safe cells containing protrusions (i.e., anchoring devices) conducive to suicide by hanging. It is well established that hanging is the method of choice in the overwhelming majority of inmate suicides. Research has now begun to identify specific common anchoring devices in these deaths. A recent study in Texas, for example, indicated that air vent grates were utilized in over 50 percent of prison suicides by hanging (1). And a yet to be released first national study on juvenile suicides found that door knobs/hinges (21%), air vent grates (20%), bunk frames/holes (20%), and window frames (15%) were the anchoring devices utilized in most youth deaths (2). Finally, telephones with cords of varying length and located inside holding cells have been shown to be dangerous in facilitating hanging attempts (3).

Checklist for Creating a Protrusion-Free Jail Cell

Although impossible to create a "suicide-proof" cell environment within any correctional facility, it is certainly reasonable to ensure that all cells utilized to house potentially suicidal inmates are free of all obvious protrusions. As such, to ensure that inmates placed on suicide precautions are housed in "suicide-resistant" cells, facility officials are strongly encouraged to address the following architectural and environmental issues (4):

1) Cell doors should have large-vision panels of Lexan (or low-abrasion polycarbonate) to allow for unobstructed view of the entire cell interior at all times. These windows should <u>never</u> be covered (even for reasons of privacy, discipline, etc.) If door sliders are not used, door interiors should not have handles/knobs; rather they should have recessed door pulls. Any door containing a food pass should be closed and locked.

Interior door hinges should bevel down so as not to permit being use as an anchoring device. Door frames should be rounded and smooth on the top edges. The frame should be grouted into the wall with as little edge exposed as possible.

In older, antiquated facilities with cell fronts (i.e., walls and/or cell doors made of steel bars), Lexan paneling (or low-abrasion polycarbonate) or security screening (that has holes that are ideally 1/8 inches wide and no more than 3/16 inches wide or 16-mesh per square inch) should be installed from the *interior* of the cell.

Solid cell fronts must be modified to include large-vision Lexan panels or security screens with small mesh;

2) Vents, ducts, grilles, and light fixtures should be protrusion-free and covered with screening that has holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch;

3) Wall-mounted corded telephones should *not* be placed inside cells. Telephone cords of varying length have been utilized in hanging attempts;

4) Cells should *not* contain any clothing hooks. The traditional, pull-down or collapsible hook can be easily jammed and/or its side supports utilized as an anchor;

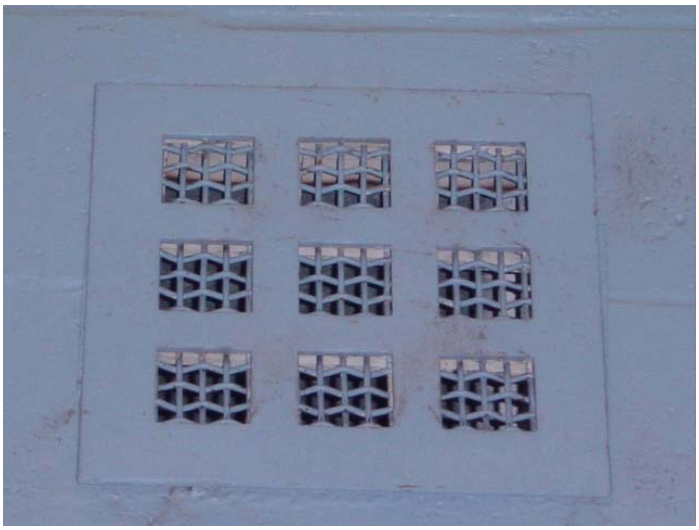
5) A stainless steel combo toilet-sink (with concealed plumbing and outside control valve) should be used. The fixture should *not* contain an anti-squirt slit, toothbrush holder, toilet paper rod, and/or towel bar;

6) Beds should ideally be either heavy molded plastic or solid concrete slab with rounded edges, totally enclosed underneath.

   If metal bunks are utilized, they should be bolted flush to the wall with the frame constructed to prevent its use as an anchoring device. Bunk holes should be covered; ladders should be removed. (Traditional metal beds with holes in the bottom, not built flush to the wall and open underneath, have often been used to attach suicide nooses. Lying flat on the floor, the inmate attaches the noose from above, runs it under his neck, turns over on his stomach and asphyxiates himself within minutes.);

7) Electricity should be turned off from wall outlets outside of the cell;

8) Light fixtures should be recessed into the ceiling and tamper-proof. Some fixtures can be securely anchored into ceiling or wall corners when remodeling prohibits recessed lighting. All fixtures should be caulked or grouted with tamper-resistant security grade caulking or grout.



Ample light for reading (at least 20 foot-candles at desk level) should be provided. Low-wattage night light bulbs should be used (except in special, high-risk housing units where sufficient lighting 24 hours per day should be provided to allow closed-circuit television (CCTV) cameras to identify movements and forms).

An alternative is to install an infrared filter over the ceiling light to produce total darkness, allowing inmates to sleep at night. Various cameras are then able to have total observation as if it were daylight. This filter should be used only at night because sensitivity can otherwise develop and produce aftereffects;

9) CCTV monitoring does *not* prevent a suicide, it only identifies a suicide attempt in progress. If utilized, CCTV monitoring should *only* supplement the physical observation by staff. The camera should obviously be enclosed in a box that is tamper-proof and does not contain anchoring points. It should be placed in a high corner location of the cell and all edges around the housing should be caulked or grouted.

   Cells containing CCTV monitoring should be painted in pastel colors to allow for better visibility. To reduce camera glare and provide a contrast in monitoring, the headers above cell doors should be painted black or some other dark color.

   CCTV cameras should provide a clear and unobstructed view of the entire cell interior, including *all* four corners of the room. Camera lenses should have the capacity for both night or low light level vision;

10) Cells should have a smoke detector mounted flush in the ceiling, with an audible alarm at the control desk. Some cells have a security screening mesh to protect the smoke detector from vandalism. The protective coverings should be high enough to be outside the reach of an inmate and far enough away from the toilet so that the fixture could not be used as a ladder to access the smoke detector and screen. Ceiling

height for new construction should be 10 feet to make such a reasonable accommodation. Existing facilities with lower ceilings should carefully select the protective device to make sure it can not be tampered with, or have mesh openings large enough to thread a noose through.

Water sprinkler heads should not be exposed. Some have protective cones; others are flush with the ceiling and drop down when set off; some are the breakaway type;

11) Cells should have an audio monitoring intercom for listening to calls of distress (*only* as a supplement to physical observation by staff). While the inmate is on suicide precautions, intercoms should be turned up high (as hanging victims can often be heard to be gurgling, gasping for air, their body hitting the wall/ floor, etc.);

12) Cells utilized for suicide precautions should be located as close as possible to a control desk to allow for additional audio and visual monitoring;

13) If modesty walls or shields are utilized, they should have triangular, rounded or sloping tops to prevent anchoring. The walls should allow visibility of both the head and feet;

14) Some inmates hang themselves under desks, benches, tables or stools/pull-out seats. Potential suicide-resistant remedies are: (a) Extending the bed slab for use as a seat; (b) Cylinder-shaped concrete seat anchored to floor, with rounded edges; (c) Triangular corner desk top anchored to the two walls; and (d) Rectangular desk top, with triangular end plates, anchored to the wall. Towel racks should also be removed from any desk area;

15) All shelf tops and exposed hinges should have solid, triangular end-plates which preclude a ligature being applied;

16) Cells should have security windows with an outside view. The ability to identify time of day via sunlight helps re-establish perception and natural thinking, while minimizing disorientation.

If cell windows contain security bars that are not completely flush with window panel (thus allowing a gap between the glass and bar for use as an anchoring device), they should be covered with Lexan (or low-abrasion polycarbonate) paneling to prevent access to the bars, or the gap should be closed with caulking, glazing tape, etc.

If window screening or grating is used, covering should have holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch;

17) The mattress should be fire retardant and not produce toxic smoke. The seam should be tear-resistant so that it cannot be used as a ligature;

18) Given the fact that the risk of self-harm utilizing a laundry bag string outweighs its usefulness for holding dirty clothes off the floor, laundry bag strings should be removed from the cell;

19) Mirrors should be of brushed, polished metal, attached with tamper-proof screws;

20) Padding of cell walls is prohibited in many states. Check with your fire marshal. If permitted, padded walls must be of fire-retardant materials that are not combustible and do not produce toxic gasses; and

21) Ceiling and wall joints should be sealed with neoprene rubber gasket or sealed with tamper-resistant security grade caulking or grout for preventing the attachment of an anchoring device through the joints.

Conclusion

The safe housing of suicidal inmates should be an integral component of a correctional facility's suicide prevention program. Decisions regarding the location of cells designated to house suicidal inmates should be based upon the ability to

maximize staff interaction with those inmates. To every extent possible, suicidal inmates should housed in the general population, mental health unit, or medical infirmary, if available, but always located close to staff. Finally, suicidal inmates should be housed in cells that are suicide-resistant, free of all obvious protrusions, and provide full visibility to staff. For as a federal appeals court once stated, "It is true that prison officials are not required to build a suicide-proof jail. By the same token, however, they cannot equip each cell with a noose." (5)

References

(1) He, X.-Y., Felthous, A.R., Holzer, C.E., Nathan, P. & S. Veasey (2001), "Factors in Prison Suicides: One Year Study in Texas," *Journal of Forensic Sciences*, 46 (4): 896-901.

(2) Hayes, L.M. (2004), *Juvenile Suicide in Confinement: A National Survey*, Washington, D.C.: U.S. Justice Department, Office of Juvenile Justice and Delinquency Prevention, forthcoming.

(3) Quinton, R. & D. Dolinak (2003), "Suicidal Hangings in Jail Using Telephone Cords, *Journal Of Forensic Sciences*, 48 (5): 1151-1152; see also Hayes, L.M. (2003), "A Jail Cell, Two Deaths, and a Telephone Cord," *Jail Suicide/Mental Health Update*, 11 (4):1-8.

(4) A portion of this checklist was originally derived from R. Atlas (1989), "Reducing the Opportunity for Inmate Suicide: A Design Guide," *Psychiatric Quarterly*, 60 (2): 161-171. Additions and modifications were made by Lindsay M. Hayes, and updated by Randall Atlas, Ph.D., a registered architect. The photographs in this article are reprinted with the permission of Dr. Atlas. He can be reached at Atlas Safety & Security Design Inc., 770 Palm Beach Lane, Miami, Florida 33138 (305/756-5027).

(5) *Tittle v. Jefferson County Commission*, 966 F.2d 606, 612 (11th Cir. 1992). ❑

Woodward v. Myres, et. al.: A Favorable Court Ruling and Large Jury Verdict for the Plaintiff

Justin Farver, 23-years-old and afflicted with cerebral palsy, was arrested for attempted sexual abuse of his niece and transported to the Lake County Jail in Waukegan, Illinois on September 24, 1998. During the booking process, Mr. Farver revealed a history of depression, bi-polar disorder, and suicidal behavior. He also expressed current suicidal ideation. Mr. Farver was eventually seen by both a social worker and psychiatrist. Although reporting a prior history of multiple suicide attempts, and current suicidal "proclivities," Mr. Farver was never placed on suicide precautions. A few weeks later on October 13, 1998, a correctional officer found Justin Farver hanging from a sheet tied to a clothing hook in his cell. He was transported to a local hospital and later pronounced dead.

In September 2000, Mr. Farver's family filed a lawsuit against several defendants, including the Office of the Lake County Sheriff, a correctional officer (Alan Myres), the jail's health services provider (Correctional Medical Services), a nurse (Karen Dean, RN), a social worker (Joel Mollner), and a psychiatrist (Michael Fernando, MD). On December 4, 2002, Judge Robert W. Gettleman of the United States District Court, Northern District of Illinois, Eastern Division, entered a ruling in ***Woodward v. Myres,*** *[WL 31744663(N.D. Ill. 2002)] which concluded that a reasonable jury could find that the actions and inactions of several defendants in the case constituted deliberate indifference to Justin Farver.*

The case is of interest for several reasons. First, there appeared to be communication problems amongst various staff (based primarily on erroneous assumptions and misinformation) regarding whether Mr. Farver was ever placed on suicide precautions in the Lake County Jail. Second, there was an issue as to whether Mr. Farver's risk to commit suicide was based upon current ideation, prior behavior, or both. And third, although the Lake County Jail had been accredited by a national correctional health care association, some health services personnel routinely ignored suicide prevention policies and the health care provider essentially condoned the behavior of these staff.

Following Judge Gettleman's opinion and order of December 2002, the parties prepared for trial. At some point prior to trial, the Farver family settled the case with the Office of the Lake County Sheriff and correctional officer Alan Myres for $60,000. On February 6, 2003 a jury trial commenced with the remaining defendants. Following several days of testimony, the jury found that nurse Karen Dean and psychiatrist Michael Fernando, MD were not liable for Justin Farver's suicide. The jury did find, however, that social worker Joel Mollner and Correctional Medical Services were jointly liable for $250,000 in general compensatory damages, and also assessed Correctional Medical Services $1.5 million in punitive damages. The full jury award to Justin Farver's estate totaled $1.75 million.

Judge Gettleman's "Memorandum Opinion and Order" in ***Woodward v. Myres,*** *[WL 31744663(N.D. Ill. 2002)] is reprinted below.*

This action stems from the October 13, 1998, suicide of Justin Farver ("Farver"), a pretrial detainee at the Lake County Jail ("the jail"). Farver's estate first filed Case No. 99 C 0290 against defendants Karen Dean, R.N. ("Nurse Dean"), Correctional Technician Alan Myres ("Officer Myres"), and Correctional Medical Services of Illinois, Inc. ("CMS"). On September 29, 2000, Farver's estate filed Case No. 00 C 6010 against Nurse Dean, CMS, Office of the Lake County Sheriff, Joel Mollner, L.C.S.W., ("Mollner") and Michael Fernando, M.D. ("Dr. Fernando").

In a memorandum opinion and order dated May 11, 2001, *Woodward v. Myres*, No. 99C0290, 2001 WL 506863 (N.D. Ill. May 14, 2001) ("*Woodward I*"), the court denied motions for summary judgment in Case No. 99 C 0290 with respect to counts IV and VI, which alleged that CMS and Nurse Dean deprived Farver of his Due Process rights guaranteed by the Fourteenth Amendment to the United States Constitution. Shortly thereafter, on May 30, 2001, this court consolidated Case Nos. 99 C 0290 and 00 C 6010. Discovery concluded on December 1, 2001.

Plaintiff's first amended complaint in Case No. 00 C 6010 asserts seven counts against defendants. Counts I, II, III, V, and VII seek damages against the Office of the Sheriff of Lake County, CMS, Nurse Dean, Mollner, and Dr. Fernando, respectively, pursuant to 42 U.S.C. §1983, for allegedly violating Farver's Fourteenth Amendment Due Process rights. Counts IV and VI assert negligence claims under the Illinois Wrongful Death Act, 740 Ill. Comp. Stat. 180/1, against Mollner, CMS, and Dr. Fernando. After the close of discovery, Nurse Dean, Mollner, Dr. Fernando and CMS moved for summary judgment with respect to plaintiff's §1983 claims against them; in addition, Mollner and Dr. Fernando moved for summary judgment with respect to plaintiff's Illinois Wrongful Death Act claims. For the reasons stated herein, defendants' motions are denied in their entirety.(1)

FACTS

In its previous summary judgment ruling with respect to Nurse Dean's and CMS' §1983 claims, the court exhaustively chronicled many of the facts underlying the instant dispute. Rather than reiterating those facts, the court refers the parties to *Woodward I*. Additional facts that have come to light since *Woodward I*, however, are summarized below, insofar as they are material to the instant motions.

To begin, plaintiff and Nurse Dean dispute whether circling "yes" in response to Question No. 8 on the Intake Mental Health Screening Form ("intake form"), and then not informing the shift commander, was appropriate conduct. In her Rule 56.1 Statement of Uncontested Material Facts, Nurse Dean states the following:

> Nurse Dean marked "yes" next to Question No. 8 on the [intake form] asking if the inmate "expresses thoughts of killing self" because Justin had harbored thoughts, in the past, that he wanted to kill himself. Nurse Dean interpreted prior suicidal thoughts as falling within the definition of "expresses thoughts of killing self" on the [intake form]. All of CMS' nurses who utilized CMS' [intake form] interpret Question No. 8 in the same manner as Nurse Dean. (Citations omitted.)

To this end, in her deposition, Therese Fryksdale, R.N., formerly a supervising nurse for CMS, testified that "[Question No. 8] is a past, present, future kind of question that is further defined by some of the questions on the [intake form]," and that, "on occasion" a nurse will circle "yes" in response to Question No. 8, yet not inform the shift commander.

In response, plaintiff points to the following deposition testimony of Mary Petkus, R.N.:

> Q. Number eight: Expresses thoughts about killing self. That was one of the answers that was shaded; is that correct?
>
> A. Yes, sir.
>
> Q. It would be required then that the shift commander be notified?
>
> A. Absolutely.

In addition, plaintiff's expert, Robert Greifinger, M.D.,(2) stated that Nurse Dean's failures to "alert the shift commander as per the instructions on the [intake] form" and to "call for an immediate mental health evaluation" of Farver constituted beaches of the standard of care.(3) According to Dr. Greifinger, "[Nurse Dean did not have] the training or experience in suicide risk assessment to override a carefully constructed document that has been developed over decades of research on risk factors for suicide." Syed Ali, M.D., another expert retained by plaintiff, similarly testified that, in failing to alert the shift commander, Nurse Dean deviated from the standard of care applicable to her.

The parties further dispute the functions of the "Summary" and "Disposition" sections on the intake form. The "Summary" portion of the form allows the writer to chose from the following options in rating the detainee: "(1) No mental health problems; (2) Mental health problems requiring routine follow-up; (3) Chronic mental health problem — (a) Mental Illness; (b) Developmental Disability; or (c) Other; (4) Acute mental health problem — (a) Psychosis; (b) Suicidal; or (c) Other; (5) Potential withdrawal from substance abuse." The "Disposition" portion of the intake form gives the writer the following options: (1) Approved for General Population: No Mental Health Referral; (2) Approved for General Population: routine Mental Health Referral; (3) Special Housing: Mental Health Referral ASAP; (4) Suicide Precaution Procedures: Mental Health Referral ASAP; (5) Psychiatric Referral; (6) Medical Monitoring for Potential Withdrawal."(4)

According to Nurse Dean's deposition testimony, because she knew that Farver was already going to be placed in the medical pod, where inmates receive routine mental health evaluations within two weeks of placement, she did not complete the "Disposition" and "Summary" sections of the intake form. Nurse Fryksdale testified that these omissions did not constitute a breach of the standard of care.

As plaintiffs point out, however, the plain text of the "Disposition" and "Summary" sections of the intake form refers to the necessary restrictions and conditions of a detainee's housing, such as suicide precaution measures, medical monitoring, and mental health referrals, in addition to housing assignments. Moreover, plaintiff's expert, Dr. Greifinger, testified in his deposition that Nurse Dean's failure to fill out the "Disposition" and "Summary" sections constituted a breach of the standard of care.(5)

The parties do not dispute that the space for a supervisor's reviewing signature is conspicuously blank on Farver's intake form. According to Nurse Fryksdale's deposition testimony, the supervising nurse had occasion to review and sign the intake form only for "inmates who were deemed by [her] staff to have any exceptional needs," such as when an inmate or detainee was suicidal and needed an immediate referral to a psychiatrist or social worker. Aside from characterizing Nurse Fryksdale's statements as "self-serving," plaintiff does not assert a factual basis for disputing her testimony on this issue.

In support of the instant motion, defendant attached excerpts from CMS' Policy and Procedures Manual. In pertinent part, No. 31.01 provides as follows.

> Inmate with no current problems, but a history of psychiatric problems, will be referred to mental health staff by completion of a Referral to Mental Health form…(a) If referral suggests imminent risk, the inmate will be placed under constant observation until evaluation by mental health staff can be completed; (b) If referral indicates need for routine follow-up, inmate will be evaluated by mental health staff within three working days.

The parties agree that all patients in the medical pod undergo a mental health evaluation within fourteen days of arriving at the jail. Moreover, the parties do not dispute that CMS' Lake County operation has been accredited by the National Commission on Correctional Health Care (NCCHC) for the past twelve years, and that CMS' policies and procedures manual is modeled after the NCCHC standards.

On October 1, 1998, Farver received a mental health evaluation from Mollner. On Farver's Mental Health Intake Evaluation form, Mollner noted that Farver was not currently receiving psychotropic medication and that, although he was considered by Mollner to be "coherent, oriented, and rational," Farver felt, "anxious, depressed, and not himself." In response to the question, "History of suicidal ideation or behavior?" Mollner circled "Yes," and added the following:

> Over 10 self-destructive episodes. Most recent, 1995. Feels current suicidal proclivities as he knows what he did was wrong [and he is] not looking to spend rest of his life in prison. Over 10 psychiatric hospitalizations, most recent 4/95, for suicide attempt. Single, no children. Employed in child care [and] has cerebral palsy. Felt anxious.

In response to "treatment plan, " Mollner wrote: "depressed, angry." Several days later, Mollner referred Farver to the jail psychiatrist, Dr. Fernando. Mollner did not request that Farver be placed on suicide watch, however, erroneously believing that Farver's placement in the medical pod meant that he must have already been on suicide watch.(6)

Plaintiff has provided the sworn statement of Willie Marie Clark, R.N. ("Nurse Clark"), originally identified as a defense witness in the instant case, as evidence that Mollner was resistant to placing inmates on suicide watch.(7) According to Nurse Clark:

> Q. So were there occasions where an inmate told you he had feelings of suicide and you checked it on the form and you gave the form to Mr. Mollner to put it on his desk and he reprimanded you for doing that?
>
> A. Yes.
>
> Q. Was that a frequent problem?
>
> A. Very frequent….He would come in ranting and raving, waiving [sic] the paper up in his hand and he's almost to the point of yelling and slapping the paper on his hand and, you know, telling me why are you giving me this? I don't need this. This person is not going to commit suicide. And he would throw the paper down….He would tell me every time you give me one of these I have to follow up on it and it's ridiculous.
>
> Q. Did you every bring Mollner's attitude in this regard to the attention of Ms. Frieksdale [sic] or Mr. Morris or Mr. Khurana?
>
> A. …I took it to Frieksdale [sic]….I told her I said what's he's saying is directly the opposite of the policy. I told her I said I know what I'm doing is the right thing. She said sure you are. She said he's just like that. Don't worry about it. Just ignore it.
>
> Q. Well, did the practice though that Mr. Mollner had of refusing to follow up on suicidal patients continue even after that conversation.
>
> A. Yes, it did. And also I have — I had nurses come to me, you know, on my shift and they would say do you think I should put this person on suicide watch because you know we are going to hear it with Joe….

Nurse Clark's observations were echoed by Rachel Schriener, L.P.N. ("Nurse Schreiner"), who stated in her deposition that she observed other nurses coming to work drunk. With respect to CMS' adherence to its stated policies, Nurse Schreiner testified.

> Q: [W]as it your impression that what was really going — the actual reality of what was going on at the jail was not consistent or didn't meet what was written in the manual?
>
> A: Yes.
>
> Q: How so?
>
> A: There were just so many things….

Nurse Schreiner also testified that the jail was, at times, a month behind in conducting intakes and that this had an impact on the quality of care being given to the inmates. According to Nurse Schreiner, "[P]eople could fall through the cracks.

Dr. Fernando evaluated Farver on October 11, 1998. His Psychiatric Evaluation form noted that Farver requested to see him "[because] of recent suicidal thinking" and described Farver as feeling "hopeless, helpless, worthless." Dr. Fernando prescribed Zoloft, an anti-depressant, and Ativan, a tranquilizer, both of which were administered to Farver on October 12, 1998 and October 13, 1998.(8) The parties do not dispute that Ativan begins working almost immediately, whereas the Zoloft takes weeks to improve depressive symptoms in "the vast majority of patients."

Dr. Fernando understood, incorrectly, that Farver was on suicide watch. According to his deposition testimony, "Practically all the inmates that are in medical are on some sort of observational status. Particularly given what I knew about him from what this person authored on the assignment sheet, that suggested to me that he was on a suicide watch." The assignment sheet indicated that Farver had some "current suicidal ideations," as well a ten prior psychiatric hospitalizations.

Discussion

A movant is entitled to summary judgment under Fed. R. Civ. P.56 when the moving papers and affidavits show there is no genuine issue of material fact and the movant is entitled to judgment as a matter of law. *See* Fed. R. Civ. P. 56(c); *Celotex Corp. v. Catrett*, 477U.S. 317, 322 (1986); *Unterreiner v. Volkswagen of America, Inc.*, 8F.3d 1206, 1209 (7th Cir. 1993). Once a moving party has met its burden, the nonmoving party must go beyond the pleadings and set forth specific facts showing there is a genuine issue for trial. *See* Fed. R. Civ. P. 56(e); *Becker v. Tennebaum-Hill Assoc., Inc.*, 914 F.2d 107, 110 (7th Cir. 1990). The nonmoving party "must do more than simply show that there is some metaphysical doubt as to the material facts." *Matsushita Elec. Indus. Co., Ltd. V. Zenith Radio Corp.*, 475 U.S. 574, 586 (1986). "The mere existence of a scintilla of evidence in support of the [nonmoving party's] position will be insufficient; there must be evidence on which the jury could reasonably find for the [nonmoving party]." *Anderson*, 477 U.S. at 252. As always, the court considers the record as a whole and draws all reasonable inferences in the light most favorable to the party opposing the motion, *See Fisher v. Transco Services-Milwaukee, Inc.*, 979 F.2d 1239, 1242 (7th Cir. 1992). With these standards in mind, the court examines each defendant's motion to dismiss below.

Count III(9) — Plaintiff's §1983 Claim Against Nurse Dean

The crux of Nurse Dean's motion for summary judgment is that the uncontroverted evidence establishes that she interpreted "expresses thoughts of killing self" on Question No. 8 of the intake form as encompassing prior rather than current suicidal thoughts. Accordingly, Nurse Dean maintains she was not subjectively aware of a substantial risk of serious injury to Farver, and that her failure to notify the Shift Commander of Farver's affirmative response to Question No.8 did not amount to deliberate indifference. Plaintiff responds that the question of whether Nurse Dean was deliberately indifferent is a question of fact for the jury to decide. Plaintiff maintains that sufficient evidence has been presented to lead a jury reasonably to conclude that Nurse Dean knew about and deliberately disregarded Farver's need for mental health care.

"Deliberate indifference" involves more than mere negligence, but less than the purposeful or knowing infliction of harm. *Farmer v. Brennan*, 511 U.S. 825, 836 (1994). In the context of suicide cases, the deliberate indifference standard of liability requires that " a prison official must be cognizant of the significant likelihood that an inmate may imminently seek to take his own life and must fail to take reasonable steps to prevent the inmate from performing this act." *Estate of Novack v. County of Wood*, 226 F.3d 525, 529 (7th Cir. 2000).

The deliberate indifference standard is subjective: "[The] official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and [he] must also draw the inference." *Farmer*, 511 U.S. 825 at 837. Plaintiff need not present direct evidence of Nurse Dean's knowledge that a substantial risk of suicide existed, however. A jury could make that inference based solely on a finding that the risk was obvious. *See id*. At 842 ("Whether a prison official had the requisite knowledge…is a question of fact subject to demonstration in the usual ways…and a fact finder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious."). Thus, at this stage of the litigation, plaintiff need produce only enough evidence upon which a reasonable jury could base a finding that the risk that Farver would commit suicide was obvious, and yet Nurse Dean did nothing to prevent that harm.

The court finds that plaintiff has met this requirement. To begin, there is a genuine issue of material fact as to whether Nurse Dean knew that Farver's mental state posed a substantial risk to his safety. Nurse Dean maintains that when she asked Farver whether he had any current thoughts of taking his life, he responded negatively. Nonetheless, in her response to Question No. 8 on the intake form, "Expresses thoughts about killing self?" she circled "Yes." In an effort to explain this seeming inconsistency, Nurse Dean maintains that "thoughts" includes present thoughts, as well as past thoughts, and she has produced evidence that other CMS nurses interpret the form in the same manner.

Nurse Dean contends that when she circled "Yes" in response to Question No.8, she as referencing only Farver's past thoughts of

killing himself (for example, his 1995 suicide attempt). Thus, when she considered the affirmative response to Question No. 8 in the context of Farver's other responses to her questions, as well as the judge's order to direct Farver to the medical pod, Nurse Dean did not feel compelled to notify the shift commander that Farver needed an immediate mental health evaluation, and she did not place Farver on suicide watch.

Notwithstanding Nurse Dean's after-the-fact explanation, a reasonable jury could find that Nurse Dean was subjectively aware of Farver's suicidal proclivities based on her affirmative response to Question No. 8. The mental health screening form posed a simple question in present tense, and Nurse Dean made no effort on the form to modify the response she gave to that question to indicate that it referred to past events, notwithstanding her modifications to other questions on the intake form.(10)

Nurse Dean's understanding that Farver would receive a mental health examination as a result of his placement in the medical pod does not alter the court's conclusion. A patient who is placed in the medical pod without a mental health referral may not receive a mental health evaluation until fourteen days after placement. In the instant case, Farver received his mental health evaluation seven days after being placed in the medical pod. Had Nurse Dean notified the shift commander of her affirmative response to Question No. 8, however, Farver would have received a mental health examination within 72 hours, which may have led to a more prompt evaluation by Dr. Fernando and more timely and effective administration of anti-depressants. Accordingly, Nurse Dean's belief that Farver would ultimately receive a mental health evaluation in the medical pod does not excuse her failure to notify the shift commander of Farver's suicidal thoughts.

As noted in *Woodward I*, even if Nurse Dean was not subjectively aware of the risk that Farver would take his own life, a reasonable trier of fact could certainly find that such a risk was obvious. Nurse Dean knew that: (1) Farver had attempted suicide in the past; (2) Farver's mother had attempted or committed suicide; (3) Farver suffered from cerebral palsy; (4) Farver had a history of psychotropic medications and psychiatric hospitalization; and (5) Farver was "always worried."

Nurse Dean's attempt to characterize her decision in the instant case as a treatment decision, that is more properly framed as the basis for a medical malpractice case, is unpersuasive. According to Nurse Dean, "At best, the basis of the plaintiff's claim is that there is a conflict between medical professionals over the possible interpretations of the [intake form]." As the court noted in *Woodward I*, however, deliberate indifference may be inferred from treatment decisions that constitute "such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible did not base the decision on such a judgment." *Woodward I*, 2001 WL 506863, at *5, quoting *Estate of Cole by Pardue v. Fromm*, 94 F.3d 254, 261-262 (7th Cir. 1996).

The directive at the bottom of the intake form does not instruct the prison official to notify the shift commander only in the event that there is an affirmative response to Question No. 8 with respect to *present* suicidal thoughts; the form unambiguously says, "If there

JAIL MENTAL HEALTH SERVICES INITIATIVE FROM THE NATIONAL INSTITUTE OF CORRECTIONS (JAILS DIVISION)

Nearly 6 to 8 percent of the more than 10 million annual commitments to jails are individuals with severe mental illnesses. Many sheriffs and jail administrators view the challenge of responding to the needs of this population as one of the major issues in jail management. In response, the National Institute of Corrections (NIC) has worked collaboratively with the National Institute of Mental Health for the past several years, and more recently, with the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services to increase and improve these services. As a result of these collaborations, the NIC Jails Division has developed a mental health initiative for jails.

An important component of the initiative is the offering of regional workshops conducted in collaboration with state, regional, and local jurisdictions. The 21-hour regional workshops will be provided upon request to help small and medium-sized jails enhance mental health services and service delivery for inmates. Several jurisdictions in a region can each send a three-person team consisting of a jail administrator, a representative of the jail's community mental health provider, and the person who coordinates mental health services for inmates. Each workshop will include: overview of the problem, planning principles, contract development, leadership and managing change, implementation strategies, staffing and cross-training, and coalition building. The workshops are conducted at the request of a host agency, which is responsible for furnishing the training rooms and equipment. The NIC Jails Division provides two trainers, the curriculum and training materials. Participants are responsible for their own expenses.

In addition to the workshops, the NIC Jails Division's mental health initiative includes the following services:

- **On-site Technical Assistance**: This assistance usually consists of an assessment of a jail system's mental health needs, *but also can be targeted at suicide prevention issues in the jail*;
- **Newsletter**: The NIC Jails Division funds the ***Jail Suicide/Mental Health Update***, a newsletter which is distributed free of charge on a quarterly basis;
- **Information Resources**: The NIC Information Center has compiled a jail mental health information resource order form that contains 22 items. The form is available at the mental health workshops held in Longmont, Colorado and at regional sites. It can also be obtained by calling the Information Center at (800) 877-1461.

For more information on the NIC Jails Division's mental health initiative, on-site technical assistance, and the mental health workshops, contact the agency at (800) 995-6429, or visit their website at: www.nicic.org

are *any* [yes] circles in shaded areas…alert the Shift Commander and refer for Mental Health Evaluation." (Emphasis added). Moreover, notwithstanding her documentation of Farver's past suicide attempts, psychiatric hospitalizations and psychotropic medications, Nurse Dean did not refer Farver for a mental health evaluation, in direct contravention of CMS' guidelines.

That Nurse Dean decided to ignore the collective wisdom of the drafters of the intake form and CMS guidelines could lead a trier of fact to reasonably find that she was deliberately indifferent in the instant case. Indeed, both plaintiff's experts and Nurse Dean's colleagues have testified that failing to notify the shift commander after circling "yes" in response to Question No. 8 constitutes a breach of the standard of care. Moreover, Nurse Schreiner's testimony that Nurse Dean curtailed her own training on how to use the intake form and "didn't like being told what to do," further supports a finding that Nurse Dean deviated from the standard of care. Exactly how far Nurse Dean deviated from the standard of care, however, and whether it constitutes "such a substantial departure" from accepted medical judgment as to rise to the level of deliberate indifference, is a question for the trier of fact."(11)

Notwithstanding additional depositions and exhibits submitted in support of Nurse Dean's renewed motion for summary judgment, the court concludes that the explicit language on the intake form, taken together with Farver's history of mental health problems, could lead a reasonable jury to find that Nurse Dean acted with deliberate indifference. As the court noted in *Woodward I*, 2001 WL 506863, at *5:

> The fact of the matter is that Nurse Dean failed to notify the shift commander as directed by the form she filled out during her examination of Farver, she failed to summarize or recommend a disposition on that form, and she failed to have that form reviewed by her supervisor. Consequently, Farver was not placed on suicide watch, he was not given an immediate mental health screening, and he was not placed on an immediate treatment program. The court agrees with plaintiff that even though, in retrospect, Nurse Dean's failures may appear to be diluted by the intervening days or events prior to Farver's suicide, a reasonable jury could still find that Nurse Dean acted with deliberate indifference to the known or obvious substantial risk that Farver would take his own life.

Accordingly, Nurse Dean's motion for summary judgment with respect to Count III is denied.

Count V — Plaintiff's §1983 Claim Against Mollner

Applying the standards enumerated above to Mollner, the court concludes that a reasonable jury could find that Mollner acted with deliberate indifference to the obvious and substantial risk that Farver was going to take his own life. As described earlier, Mollner's evaluation noted that Farver felt "anxious, depressed, and not himself," as well as depressed, angry." In response to the question, "History of suicidal ideation or behavior?" Mollner circled "yes," and added the following:

> Over 10 self-destructive episodes. Most recent, 1995. Feels current suicidal proclivities as he knows what he did was wrong [and he is] not looking to spend rest of his life in prison. Over 10 psychiatric hospitalizations, most recent 4/95, for suicide attempt. Single, no children, Employed in child care [and] has cerebral palsy. Felt anxious.

Notwithstanding these observations, Mollner now maintains that he was not aware that Farver was suicidal. According to Mollner's deposition testimony:

> There was nothing specific. There was no specific ideation. He never talked about what he might do or what he could do. There was never any mention of a plan. Nor was there any indication or mention that he would ever enact on anything. So the amount of suicidal ideation — it was just a general, very mild kind of thing. So there was no indication to think that it was all that serious.

Assuming that a jury believed Mollner's testimony that he was not subjectively aware of Farver's desire to take his own life, the court concludes a jury could still find that Mollner overlooked an obvious risk that Farver was suicidal. Mollner knew that Farver had more than ten self-destructive episodes, that he felt current suicidal proclivities, that he knew what he did was wrong, and that he was not looking to spending the rest of his life in prison.(12)

Mollner also suggests that he did not fail to take reasonable steps to protect Farver, because he reasonably believed that Farver's placement in the medical pod meant that he was already on suicide watch.(13) The evidence, however, could lead a reasonable jury to conclude that Mollner was indeed deliberately indifferent in not taking further action to respond to Farver's suicidal proclivities.

Mollner concedes that not every patient in the medical pod was on suicide watch. Nonetheless, at his deposition, he testified that he assumed Farver must have been in the medical pod because of a suicide watch, since Farver's cerebral palsy was "so mild" that it would not have necessitated placement in the medical pod.

Drawing all reasonable inferences in plaintiff's favor, however, the court concludes that a reasonable jury could find that Mollner's failure to place Farver on suicide watch constitutes deliberate indifference.(14) Although Mollner may have indeed perceived Farver's cerebral palsy to have been mild, it made a sufficient impression upon Mollner to note it under the section of his evaluation titled, "Clinical Impression." A jury could reasonably infer, therefore, that Mollner knew that Farver was in the medical pod not because of a suicide watch, but rather because of his cerebral palsy. Although this inference may seem somewhat attenuated when considered in light of Nurse Clark's testimony that Mollner routinely scolded nurses for placing patients on suicide watch, it may lead a trier of fact to conclude that Mollner was averse to putting suicide precautions in place for Farver — and that he was deliberately indifferent to a substantial risk that Farver would take his own life.(15)

That Farver was placed in between the cells of two other inmates who were on suicide watch does not alter the court's conclusion.

Those inmates were allowed access to the medical pod dayroom, while Farver was in "lockdown," restricted to his cell, where on the day of his suicide he lay beneath his blanket fashioning the noose with which he hanged himself from the laundry hooks on his cell wall. As the court noted in *Woodward I*, 2001, WL 506863, at *8, had the jail staff been warned of Farver's suicidal condition,

> Farver would not have been allowed to lie in bed all day unchecked, he would not have been granted access to the telephone he would not have been placed on lockdown, Myers [sic] would not have answered Farvers' question the way he did, or Farver would have been moved to a padded room or a room without hooks on the wall — and that any one of these differences in the events that occurred during Farver's incarceration would have saved his life.

The court thus rejects Mollner's argument that "being on a 'formal' suicide watch would have changed nothing in connection with Justin's circumstance."

The court concludes, therefore, that material issues of fact exist with respect to Mollner's conduct that could lead a jury to conclude that he was deliberately indifferent to a substantial and obvious risk that Farver would take his life. Accordingly, Mollner's motion for summary judgment with respect to Count V is denied.

Count VII — Plaintiff's §1983 Claim Against Dr. Fernando

Like Mollner, Dr. Fernando argues, albeit inconsistently, that, (1) he did not know that Farver was suicidal, and (2) he assumed Farver was on suicide watch, and that, as a result, he was not deliberately indifferent. Although the evidence produced against Dr. Fernando is perhaps less voluminous than that presented against Mollner and Nurse Dean, the court concludes that Dr. Fernando is not entitled to summary judgment on plaintiff's §1983 claim.

First, the court concludes that, at the very least, a jury could reasonably conclude that the risk that Farver would commit suicide was obvious. Farver was referred to Dr. Fernando for "recent suicidal thinking." In his write-up of his evaluation, Dr. Fernando noted that Farver felt "hopeless, helpless, worthless," and later testified in his deposition that Farver "was manifesting current suicidal thinking or ideations, but no intent, no plan, and no means." Moreover, in response to the question, "[W]as there anything about your evaluation of [Farver] when you saw him that suggested he did not need to be on a suicide watch?" Dr. Fernando testified "No." These facts alone lead the court to conclude that a reasonable trier of fact could find that the risk that Farver would take his own life was obvious, and that Dr. Fernando was subjectively aware of that risk.

With respect to whether Dr Fernando was deliberately indifferent to this risk and therefore did not take reasonable steps to prevent Farver's suicide, the court again directs the parties' attention to ease with which Dr Fernando and Mollner could have confirmed that Farver was or was not on suicide watch. Indeed, nothing in Farver's file indicated that suicide precautions had been taken, and the 17-day lapse between his placement in the medical pod and his evaluation by Dr. Fernando should have belied any inference that he was on suicide watch.(16) Accordingly, the court finds that Dr. Fernando is not entitled to summary judgment on Count VII.

Counts IV and VI — Illinois Wrongful Death Claims Against Mollner and Fernando

As noted earlier, deliberate indifference involves more than mere negligence, but less than the purposeful or knowing infliction of harm. *Farmer v. Brennan*, 511 U.S. 825, 836 (1994). Accordingly, having established that plaintiff has produced sufficient evidence from which a jury could conclude that Mollner and Dr. Fernando acted with deliberate indifference to a substantial or obvious risk that Farver would take his life, the court finds that a reasonable jury could also conclude that Mollner and Dr. Fernando were negligent in their treatment of Farver.

Before turning to the next claim, the court pauses to address an evidentiary dispute regarding the experts in this case. Mollner and Dr. Fernando make much of the fact that Dr. Greifinger is a licensed pediatrician, arguing that, under both Illinois substantive law and Fed. R. Evid. 702, he is not qualified to render an opinion on the standard of care applicable to social workers and psychiatrists.(17) While plaintiff apparently concedes that expert testimony is required to establish the standard of care applicable to Mollner and Dr. Fernando with respect to her Illinois Wrongful Death Claims, she disputes defendants' contention that Dr. Greifinger is not qualified to provide that testimony. For the reasons discussed below, the court concludes that Dr. Greifinger is qualified to render expert testimony in the instant dispute.

In a diversity case, the admissibility of an expert's testimony is a question of procedure that is governed by federal law, specifically Fed. R. Evid. 702. *See Stutzman v. CRST, Inc.*, 997 F.2d 291, 295 (7th Cir. 1993) (holding that the Federal Rules of Evidence governing expert testimony are procedural and this applicable in federal diversity cases); *Allstate Ins. Co. v. Sunbeam Corp.*, 865 F. Supp. 1267, 1275 (N.D.Ill. 1994) ("If the state law rule is a rule of admissibility of expert evidence, it does not apply in federal court.").

Rule 702 provides that, if scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence, "a witness qualified as an expert by *knowledge, skill, experience, training, or education*, may testify thereto in the form of an opinion or otherwise…." (Emphasis added.) Before admitting expert testimony, the district court judge should assure himself that "the expert knows whereof he speaks." *Bammerlin v. Navistar International Transportation Corp.*, 30 F.3d 898, 901 (7th Cir. 1994). To this end, the district court judge acts as a "gatekeeper whose role is to keep experts within their proper scope." *Smith v. Ford Motor Co.*, 215 F.3d 713, 718 (7th Cir. 2000) (internal quotations omitted). This gatekeeping function applies to all expert testimony. *Kumbo Tire Co., Ltd. V. Carmichael*, 526 U.S. 137, 119 S.Ct. 1167, 1174.

Although academic expertise may certainly be sufficient to qualify a potential witness as an expert, the plain text of Rule 702 also includes experience, knowledge, skill and training as means of

qualification. Accordingly, "a court should consider a proposed expert's full range of practical experience as well as academic or technical training when determining whether that expert is qualified to render an opinion in a given area." *Smith,* 215 F.3d at718. Rule 702 does not require an expert to possess particular credentials. *Erickson v. Baxter Healthcare, Inc.*, 151 F. Supp. 2d 952, 964 (N.D.Ill. 2001).

The gravamen of plaintiff's complaint in the instant dispute is that Mollner and Dr. Fernando failed to put Farver, a pretrial detainee, on a suicide watch after documenting that he had suicidal thoughts and proclivities. Dr. Greifinger served as the Chief Medical Officer for the New York State Department of Corrections from 1989 through 1995, and is a Fellow for the Society of Correctional Physicians. In addition to providing expert testimony in numerous federal and state courts regarding mental health care and suicide prevention policies at correctional facilities, Dr. Greifinger serves as a Principal Investigator for the National Commission on Correctional Health Care. The matters about which he will presumably testify in the instant case are clearly within his full range of practical experience, even if he has not practiced as a social worker or psychiatrist per se.(18)

Count III(19) — Plaintiff's §1983 Claim Against CMS

The gist of plaintiff's §1983 claim against CMS is that, notwithstanding CMS' published procedures and policies, the practices engaged in by CMS staff were wholly inappropriate and violated Farver's Fourteenth Amendment Due Process Rights. To this end, plaintiff has produced evidence that the staff routinely violated stated CMS' policies with respect to intake, training and suicide precautions, and that these violations were essentially condoned by CMS officials with policymaking authority who failed to take steps to ensure that CMS' policies, as written, were actually enforced.

Municipality liability under §1983 arises when the execution of a government's policy or custom inflicts injury.(20) *Estate of Novack,* 226 F.3d at 531, (quoting *Monell v. Department of Soc. Svcs.*, 436 U.S. 658, 694 (1978)). As the court noted in *Woodward I*, there are two ways for a plaintiff to establish that a constitutional injury was caused by a municipality's policy or custom. First, there is the direct method, which requires the plaintiff to show that the municipality's policy or custom is itself unconstitutional. *Estate of Novack,* 226 F.3d at 531 (citing *Monell v. Department of Soc. Svcs.*, 436 U.S. 658, 694 (1978)). Second, there is the indirect method, which requires showing "a series of bad acts and inviting the court to infer from them that the policymaking level of [the entity] was bound to have noticed what was going on and by failing to do anything must have encouraged or at least condoned, thus in either event adopting, the misconduct of subordinate [employees]." *Estate of Novack,* 226 F.3d at 531 (quoting *Jackson v. Marion County,* 66 F.3d 151, 152 (78th Cir. 1995)).

Plaintiff does not challenge the appropriateness of constitutionality of CMS' policies and procedures manual itself, conceding that the policies, as written, are consistent with due care. Rather, the crux of plaintiff's §1983 claim is CMS' "consistent and unremitting disregard of its own [stated] policies." According to plaintiff, the "prevailing practice on the medical pod of the jail was chronically substandard and…CMS supervisors were aware of [this]."(21)

Monell teaches that, "it is when execution of [an entity's]…custom…inflicts the injury that the [entity]…is responsible under §1983." 436 U.S. at 694. The question becomes, then, whether a reasonable jury could find that it was CMS' custom of repeatedly failing to act to ensure Farver's safety that led to his successful attempt to commit suicide.(22) The facts in the instant case answer that question affirmatively. Plaintiff has produced testimony from both Nurse Clark and Nurse Schreiner that suggests that CMS officials with decisionmaking authority routinely tolerated, and essentially condoned, their subordinates' repeated violations of CMS' stated policies and procedures. For example, according to Nurse Clark, Mollner's refusal to adhere to CMS' stated policy regarding the implementation of suicide precautions for patients like Farver was known by numerous nurses and at least one supervising nurse, Nurse Fryksdale. Further, Nurse Fryksdale testified that "on occasion" a nurse will circle "yes" in response to Question No. 8, yet not inform the shift commander, which is in direct contravention of the directive on the intake form, and arguably prevents suicidal patients from receiving appropriate and timely intervention.(23)

Given CMS' alleged rampant disregard for its own stated policies and procedures, the court concludes that a reasonable jury could find that CMS' custom of failing to intervene and provide appropriate services for potentially suicidal inmates caused Farver's death. Accordingly, CMS' motion for summary judgment on Count II is denied.

Conclusion

For the reasons stated herein, defendants' motions for summary judgment are denied.

Footnotes

(1) Because of the additional evidence adduced in support of the instant motions for summary judgment, the court construes Nurse Dean's and CMS' motions as renewed motions for summary judgment rather than motions to reconsider.

(2) Dr. Greifinger, a licensed pediatrician, served as the chief medical officer for the New York State Department of Correctional Services from1989 through 1995.

(3) Dr. Greifinger also cited Nurse Dean's failure to, (1) complete the "Summary" and "Disposition" sections of the form, (2) retrieve Farver's prior medical records, and (3) notify her supervisor of Farver's suicide risk, as breaches of the standard of care.

(4) Numbering supplied for clarity; the actual form has blank lines for the writer to mark with an "X" or check.

(5) Rachel Schreiner, L.P.N., further testified that, with respect to CMS' initial training on how to conduct intakes, Nurse Dean did "not want to complete her orientation…as though she didn't want to be told what to do." When asked whether she reported Nurse Dean's behavior to her supervisors, she responded, "I don't know if I did. I think at that point it wouldn't have done any good anyway….Because [Nurse Fryksdale] wasn't really good at responding to things like that."

(6) In October 1998, inmates who were placed on suicide watch were housed either in the medical pod or in a cell in the booking area. Mollner acknowledges that not all patients on the medical floor are on suicide watch. Nonetheless, he testified in his deposition that he "wasn't aware of any other reason" that Farver would have been there, as Farver's cerebral palsy "was so mild that that didn't cross [his] mind that that's why [Farver] was up there [in the medical pod]."

(7) Defendants have moved to strike Nurse Clark's sworn statement because "the plaintiff did not obtain or produce the statement during discovery and did not even disclose the existence of the statement until after the defendants filed their motions for summary judgment." The court agrees with defendants that Nurse Clark's sworn statement is not properly characterized as privileged work product, and that the contents thereof are indeed discoverable. Having said that, however, the court notes that although defendants may have been surprised by the contents of Nurse Clark's sworn statement, they certainly could not have been surprised that she had information that is material to the instant dispute. Indeed, in their October 12, 2001, Supplemental Answers to Plaintiff's Interrogatories, defendants disclosed Nurse Clark as a potential witness. Thus, rather than striking the statement, the court concludes that the appropriate remedy is to reopen discovery for the limited purpose of allowing defendants to depose Nurse Clark.

(8) Plaintiff disputes that the medications were properly administered, based on Nurse Clark's sown statement that she had, on more than one occasion, observed nurses who were under the influence while administering medication to inmates. By itself, however, this testimony, relating to conduct that did not occur on October 12 or 13, 1998, does not undermine defendant's contention that the Ativan and Zoloft were properly administered to Farver.

(9) In Case No.99 C 0290, plaintiff's §1983 claim against Nurse Dean was designated as Count VI.

(10) Additionally, there is some indication from her testimony that Nurse Dean might have recklessly discounted Farver's suicidal proclivity based on the fact that "there was [sic] no trains" in the jail, making his thoughts of suicide "irrelevant" in her estimation. *See Woodward I,* 2001 WL 506863, at *1.

(11) That specific procedures existed at the jail for completing the intake form, processing inmates who responded affirmatively to Question No. 8, and further evaluating inmates who had a history of psychiatric hospitalizations and medications, distinguishes this case from *Sanville v. McCaughtry,* 2166 F.3d 724 (7th Cir. 2001). Thus, Dr. Greifinger's testimony that Nurse Dean could have concluded that Farver was not acutely suicidal does not preclude a finding of deliberate indifference in the instant case. Indeed, Dr Greifinger concluded in his expert report that Nurse Dean's failures to, (1) properly complete the intake form, (2) notify the shift commander, and (3) refer for mental health evaluation, constituted deliberate indifference, notwithstanding Nurse Dean's conclusion that Farver was not acutely suicidal.

(12) Whether Farver was "acutely suicidal," as the term is used clinically, is fiercely disputed by the parties. Mollner testified in his deposition that he did not interpret Farver's suicidal proclivities as evidence that Farver was acutely suicidal. Plaintiff's expert, Dr. Greifinger, disagreed with Mollner's conclusions in this regard. It is possible, however, that this debate is merely academic. Indeed, Mollner himself testified that even mild suicidal ideation is sufficient to put an inmate on suicide watch: "There has to be some specifics. You can't just be a mild, you know, I don't feel like I should live anymore. I mean, that would put someone on a watch but that's not acute."

(13) The court notes the inconsistency between Mollner's insistence that he was not aware of the risk of Farver's suicide and his testimony that the believed Farver was on suicide watch.

(14) Plaintiff also points to Mollner's delay in referring Farver to Dr. Fernando for an evaluation as further evidence of deliberate indifference. According to Mollner, when he first proposed sending Farver to Dr. Fernando, Farver declined because he did not like the side effects of psychotropic medications. Mollner testified that, several days later, Farver sent him a note requesting to see Dr. Fernando, at which point he was referred for a psychiatric evaluation on October 11, 1998. Neither the conversation in which Farver allegedly declined to see Dr. Fernando, nor the subsequent note requesting to see Dr. Fernando, are documented in any of the documents produced in discovery, however. Because the court concludes that Mollner's failure to place Farver on suicide watch is sufficient in and of itself to create a question for the jury, the court declines to assess the merits of this argument in the absence of more competent evidence.

(15) The court also notes that, if Farver had been on suicide watch, he would have been seen by Mollner within three days of his placement in the medical pod. Even a cursory review of the date of Farver's intake form, therefore, would have revealed to Mollner that Farver was not in fact on suicide watch.

(16) Neither the court not plaintiff takes issue with Dr. Fernando's prescription of Ativan and Zoloft for Farver.

(17) Defendants also dispute plaintiff's retention of Dr. Syed Ali as an expert witness, arguing that plaintiff did not comply with Fed. R. Civ. P. 26(a)(2)(A)-(C). Rule 26(a)(2)(A) provides that parties must disclose the identity of expert witnesses, and rule 26(a)(2)(b) provides that such disclosures must be accompanied by a report that includes "a complete statement of all opinions to be expressed and the basis therefore." These disclosures are to be made at the times directed by the court, or in the absence of such a directive, at least 90 days before trial. Fed. R. Civ. P. 26(a)(2)(C). A party that, without "substantial justification," fails to disclose information required by Rule 26(a), is not permitted to use that expert or his testimony at trial or on motion, unless his failure to disclose was harmless. Fed. R. Civ. P. 37(c)(1). The determination as to whether such failure was indeed harmless is left to the broad discretion of the trial court. *Brand Name Prescription Drugs Antitrust Litig.*, 2001 WL 30454, at *1 (N.D.Ill. Jan. 11, 2001) (citing *Finley v. Marathon Oil Col.*, 75 F.3d 1225, 1231 (7th Cir. 1990)). To this end, the court should consider the surprise or prejudice to the blameless party, the ability of offender to cure any resulting prejudice, the amount of disruption to trial that would result from permitting the use of the evidence, and the bad faith involved in not producing the evidence at an earlier date. *Spearman Industries, Inc., v. St. Paul Fire & Marine Ins. Co.*, 138 F. Supp. 2d 1088, 1094 (N.D.Ill. 2001) (citing *Bronk v. Ineichen,* 54 F.3d 425, 432 (7th

Cir. 1995)). Although plaintiff did not identify Dr. Ali as an expert pursuant to Fed. R. Civ. P. 26(a)(2)(A), defendants cannot colorably claim that they are surprised by his existence or the content of his opinions, since Dr. Ali was initially identified by defendants as one of their own experts. It was only after Dr. Ali's deposition testimony proved favorable to plaintiff that plaintiff decided to name him as her expert. Accordingly, defendants were not hampered in their ability to prepare for trial by plaintiff's failure to disclose Dr. Ali. There is also no evidence that plaintiff acted in bad faith by failing to disclose Dr. Ali, or that the pending trial will be disrupted by permitting plaintiff to introduce Dr. Ali's testimony. Thus, the court concludes that Dr. Ali may testify as an expert at trial.

(18) The parties appear to assume that Illinois law, rather than Rule 702, governs the court's assessment of Dr. Greifinger's competence to testify as an expert witness. Fed. 4. Evid. 601 provides, "in civil actions and proceedings, with respect to an element of a claim or defense as to which State law supplies the rule of decision, the competency of a witness shall be determined in accordance with State law." *See also, Lovejoy Electronics, Inc. v. O'Berto,* 873 F.2d 1001, 1005 (7th Cir. 1989) (citing Fed. R. Evid. 602 as an exception to the general rule that "federal rather than state law governs admissibility of evidence in federal diversity cases"); *Legg v. Chopra,* 286 F.3d 286, 291 (6th Cir. 2002) (distinguishing competence to testify, which is a substantive issue governed by state law in diversity cases, from admissibility of testimony, which is procedural and thus governed by Fed. R. Evid. 702). Assuming *arguendo,* without deciding, that an evaluation of an expert's competence to testify is indeed distinct from the court's Rule 702 admissibility analysis, the court would still permit Dr. Greifinger to testify as an expert. Under Illinois law, a physician expert generally should be a licensed member of the school of medicine about which he will testify. *Dolan v. Galluzzo,* 77 Ill.2d 279, 285 (1979); *Purtill v. Hess,* 111 Ill.2d 229, 243 (1986). This rule is animated by a concern that the expert's allegations of negligence are within the expert's knowledge and observation. *Wingo by Wingo v. Rockford Memorial Hospital,* 292 Ill. App. 3d 896, 907 (2d Dist. 1997). Thus, when the allegations of negligence are well within the expert's knowledge and experience, and do not concern an issue upon which doctors from different schools of medicine would apply different standards, the rule need not be strictly applied. *Id.* With these standards in mind, the court finds that Dr. Greifinger is competent to serve as an expert in the instant dispute. Notwithstanding the fact that he lacks a license to practice either social work or psychiatry, Dr. Greifinger's extensive experience with mental health programs within correctional facilities qualifies him to testify regarding the appropriateness of instituting suicide precautions for Farver.

(19) In Case No 99 C 0290, plaintiff's §1983 claim against CMS was designated as Count IV.

(20) CMS and plaintiff agree that CMS' potential liability under Count II is equivalent to that of a municipality under §1983 caselaw.

(21) To the extent that plaintiff's claims are based upon the misconduct of individual employees, the court notes that §1983 liability against a municipality may not be founded on theories of vicarious liability or respondeat superior. *Estate of Novack,* 226 F.3d at 530(citing *City of Canton v. Harris,* 489 U.S. 378, 385 (1989)).

(22) As the court noted in *Woodward I,* 2001 WL 506863, at *7, "It is well established…that single instances of such conduct (one example of a poorly trained employee and one example of a failure to supervise) do not establish a *Monell* claim." (Citations omitted.)

(23) Nurse Clark and Nurse Schreiner further testified that the nurses were, at some points, up to one month behind on conducting intakes, notwithstanding policy 31.01, which outlines procedures "to ensure that inmates being admitted into custody are evaluated in a timely manner for potential psychiatric problems, psychological difficulties and/or risk for suicidal behavior." According to Nurse Schreiner, this backlog could cause inmates and/or detainees to "fall through the cracks." ❑

News From Around the Country

Offered below are brief stories regarding inmate suicide, offenders with mental illness, and other related topics that have recently occurred and/or been reported throughout the country.

South Carolina

Marc Washington, 41-years-old, entered the Richland County Jail in Columbia on October 17, 2003, charged with domestic violence. Several hours later, he tried to hang himself with his shirt and then with a string from his gym shorts. Mr. Washington was subsequently transported to the Columbia Care Center, a forensic hospital run by the state Department of Mental Health.

Shortly after his return to the Richland County Jail from the state hospital on October 27, Mr. Washington's hospital records were faxed to medical staff at the jail. Although the records did not contain a doctor's order recommending that Mr. Washington needed to be placed on suicide precautions, the accompanying fax cover sheet did indicate that the inmate should be observed for continued "suicidal gestures." Mr. Washington, however, was not placed on suicide precautions. Less than 10 hours later, he was found hanging from his cell door and later pronounced dead.

According to a recent investigative report from the Richland County Sheriff's Department, a social worker from the state hospital made three attempts to notify medical staff at the county jail that Mr. Washington should be placed "on suicide watch for suicidal gestures." Investigators also found that he had not been observed by jail staff for over six hours. Two correctional officers later resigned after jail logs were found to be falsified to reflect that 30-minute cell checks were made.

While acknowledging that medical staff discarded the information on the fax cover sheet, assistant county administrator Milton Pope told *The State* that the faxed information also stated that Mr. Washington was found to be "malingering" at the hospital. He

further stated that medical staff at the jail claimed they never received a telephone message from the state hospital, and that it was standard procedure at the jail to rely solely on a doctor's signed orders. In Mr. Washington's case, those orders did not place any limitations on the inmate. "What we go by is that information that comes with the inmate," Mr. Pope said. "Why would there be differing information?"

Holly Scaturo, the forensic program manager at William S. Hall Psychiatric Institute, which was involved in Mr. Washington's treatment, said hospital staff often fax medical orders and call the jail in addition to sending the doctor's orders with the officer who picks up the inmate. "I expect if I put something in the comment section on a fax somebody would read it," Ms. Scaturo told *The State*. "Wouldn't you?"

Richland County Council member Greg Pearce, a former director of one of the state's mental hospitals, had concerns about the mental health evaluation process and the lack of communication between state mental health officials and jail staff. "When we send an individual for an evaluation, there should be no ambiguity whatsoever of what the care of the individual should be," he said.

A spokesman for the state Department of Mental Health is reviewing its procedures. Richland County officials have also said they want to meet with state officials to discuss how to handle such transfers in the future.

Washington (State)

Her 35-year-old son, Jason, who is schizophrenic and borderline mentally retarded, spent 44 days in the Thurston County Jail last year after being arrested for damaging property. For three of his six weeks in jail, the former Olympia resident was waiting for a state competency evaluation required before he could stand trial. "This is someone who needed care," Margaret Brayden said. "It caused him more mental anguish instead of helping him. It was so traumatic for my son that I moved him to Portland where I live so we could be more supportive."

On average, mentally ill inmates spend more than twice as long behind bars as other offenders in the Thurston County Jail — a crowded space with few beds to spare. Mentally ill offenders are locked up in the county jail an average of 64 days compared with an average stay of 25 days for other inmates.

The extended time frame reflects reductions made to the state's mental health system during the past few years, Thurston County corrections officials said. Recent cuts have slowed the completion of state competency evaluations and decreased the number of available hospital beds, county corrections officials said. "It used to be that it would take state hospitals one or two days before they could bring someone up for an evaluation," said Karen Daniels, Thurston County director of corrections. "Now, it takes three to four weeks, and that impacts the length of stay. It's been gradually growing in the last couple years."

The lag time has caught the attention of local advocates for the mentally ill, who claim the disparity might violate federal law. Bill Pilkey, former president of the Thurston and Mason counties chapter of the National Alliance for the Mentally Ill, said he plans to meet with an attorney this month to discuss a possible lawsuit against the county. "We're very concerned about this," Pilkey said. "We're going to be looking into it."

Officials at Western State Hospital — one of two hospitals for the mentally ill in the state — said it makes sense those offenders are in jail longer since they have to go through an evaluation process not required of other offenders. "For them to take longer in the judicial process is not unexpected because of the competency evaluation," said Ira Klein, the hospital's acting medical director. Klein also said a program enacted several years ago by the state Legislature allows some inmates to be evaluated in the jail. The doctor said he doubts inmates wait longer for evaluations now. Instead, it's probably a question of whether they are waiting in jail or at the hospital, he said. "It's very costly to do an inpatient hospital evaluation and to transport people back and forth," he said. "An evaluation can be done just as efficiently in jail. It's safer with less escape risk."

Thurston County Jail has capacity for 358 inmates, but its daily population sometimes swells beyond 500. County officials hope to alleviate crowding by constructing a 640-bed jail and courts complex at the Mottman Industrial Park in Tumwater — a project expected to cost $102.8 million. An $88 million bond issue to pay for the justice center is expected to be on the ballot for a countywide vote next year.

Mentally ill inmates are isolated from other offenders. The practice is intended to protect the mentally ill inmate and other offenders. But it also means a mentally ill offender is housed in a cell that otherwise could fit two or three people. "It means another inmate is on the floor somewhere," Daniels said.

UPDATE
ON THE INTERNET

Recent issues of the ***Jail Suicide/Mental Health Update*** are now available on the Internet at:

www.ncianet.org/cjjsl.cfm

Check us out on the Web!
www.ncianet.org/cjjsl.cfm

Other jail/juvenile suicide prevention and jail mental health resources, including several recent articles by Lindsay M. Hayes, can be found at the following web sites:

www.hhpub.com/journals/crisis/1997
www.nicic.org/jails/defrault.aspx
www.ojp.usdoj.gov/managingoffenders/mentalhealth.htm
www.ncjrs.org/html/ojjdp/jjjnl_2000_4/sui.html
www.performancebasedstandards.org
www.gainsctr.com

According to county records, 39 inmates were required to receive competency evaluations last year. Those offenders occupied Thurston County Jail beds for a total of 813 days. "One inmate spent 75 days here waiting for reports and for a (state hospital) bed to open up," Daniels said. Hospital records indicate no one in the county jail currently is waiting to receive a competency evaluation, Klein said. He also said the hospital complies with state-mandated deadlines for completing the process. "The decision to get them to stand trial is not made by the mental health system," Klein said. "It's made by the courts. It's made by the prosecutors and the sheriffs, not us."

Across the country, 40 mental health hospitals have closed in the past decade, according to the U.S. Department of Justice. During the same period, 400 new prisons have opened. "We've put money into jails and prisons, and we've closed all of these hospitals," Daniels said. The result, county officials said, is that mentally ill inmates are locked up longer, taking up space in a jail already bursting at the seams. "It's not only happening here; it's every single jail in the state," Pilkey said. "It's plain discrimination against the mentally ill."

Pierce County filed a lawsuit against the state last year alleging that the state refused to accept mentally ill inmates court-ordered to be hospitalized for treatment. State budget cuts have meant mentally ill inmates there also face longer stretches of time in jail, Pierce County officials said. The lawsuit is slated to go to trial in 2004.

"As resources dwindle at the state and local level, the likelihood that someone with a mental illness will end up in the criminal justice system increases," said Dave Stewart, Pierce County Regional Support Network coordinator for crisis in corrections and mental health. "We have looked at people charged with similar crimes, and those with mental illnesses, they did stay longer."

Mentally ill inmates behind bars at the Thurston County Jail can receive medication for their conditions. However, counseling and other support programs are not available. "They're not getting any treatment in jail," said Stacie Larson, a NAMI member from Olympia whose 45-year-old son is schizophrenic and has never been arrested. "It doesn't make sense to jail people because they're sick."

Richard Sievert, 42, suffers from chronic depression. The Olympia man was convicted of malicious mischief two years ago after a dispute with a neighbor resulted in a call to police. He spent several months in the Thurston County Jail. Sievert is a regular at Capitol Club House, a local agency whose mission is to provide a supportive environment, resources and social opportunities for those with mental health issues. Sievert thinks treatment would have served him better than jail time, he said. "I was scared, and I was upset," he said Wednesday, smoking a cigarette on the Capitol Club balcony. "Nobody listened to me. There was no counselor. Sometimes justice isn't swift."

The above article — "Mental Illnesses Increase Length of County Jail Stays" — was written by Heather Woodward, a staff writer for ***The Olympian****. It appeared in the October 9, 2003 edition of the newspaper and is reprinted with the permission of* ***The Olympian****.*

Texas

The Williamson County Jail in Georgetown is under investigation after 24-year-old Luke Ashley committed suicide by hanging on December 4, 2003. Mr. Ashley suffered from bi-polar disorder and was being held in the jail awaiting transfer to a substance abuse facility run by the Texas Department of Criminal Justice.

The Ashley family is outraged over his death. "When I think of jail, I think of criminals, murderers, rapists and robbers who harm other people or intend to harm other people and that was so not my brother," Dena Ashley Mansouri told a local television station (*News 8*) in Austin. A shortage of beds at a drug treatment facility forced him to stay at the county jail for two additional weeks.

Luke Ashley had violated the terms of probation following his conviction for possession of a controlled substance. His family said he used illicit drugs to control the side effects of the bi-polar disorder. "Medication is fine as one element, but if you don't have the therapy that helps them deal with their mental illness then you don't have all the elements you need for them to get well," his mother Tricia Ashley said.

Mr. Ashley became despondent on the afternoon of December 4 and called his mother asking to speak with a psychiatrist. "I called the jail and said, 'Please, you've got to get him a psychiatrist, you've got to help him,' and they said they were sorry, but the psychiatrist only visits on Saturdays," Mrs. Ashley said. Her son was, however, placed on suicide precautions by jail staff. Despite increased observation, Mr. Ashley managed to commit suicide several hours later.

The Ashley family remains incredulous. "Why did he have anything in there, a sheet, towel, pair of pants, anything, if he was suicidal?" his mother said. Jack Hall, spokesman for the Williamson County Sheriff's Office responded by stating that "you can't deny them a towel, we don't give them sheets as it is, we give them a blanket, mattress, and mattress cover, which are all required by state law." He also stated that the department's internal affairs investigation will eventually show that no policies or procedures were violated in the case.

Montana

Following three inmate suicides at the Montana State Prison in Deer Lodge during 70-day span last summer, prison officials recently announced a plan they hope will deter future deaths. The plan includes increased observation of suicidal inmates, additional suicide prevention training for staff, and physical plant enhancements. ''When you see so many in a short time frame, you want to be real aggressive and get on top of it," Warden Mike Mahoney told the *Independent Record* on November 8, 2003.

The rash of suicides began on July 8 when Douglas Turner, 41-years-old, hanged himself in his death-row cell after spending almost half his life in prison. On August 31, 32-year-old Jon LeBeau was found hanging shortly before he was to be sentenced for murdering another inmate. According to the state medical examiner, Mr. LeBeau also had also ingested a massive dose of Zoloft prior to his death.

On September 15, Kevin Osmanson, 24-years-old with a history of emotional problems, hanged himself. In February 2003, he

had been sentenced to a pre-release center following a drug conviction. He then escaped from the facility on August 21, was taken back into custody on September 10, and transported to Montana State Prison. Mr. Osmanson was assessed as being at risk for suicide based upon current ideation and history of two prior suicide attempts in the community. He was placed on suicide precautions for two days in the prison infirmary and prescribed psychotropic medication. Mr. Osmanson was released from suicide precautions and transferred to the reception unit. Shortly thereafter, he committed suicide. "We felt we had kind of turned the corner with him," Warden Mahoney told the *Independent Record*. "He was talking about things that indicated to us he was no longer fixated upon self-harm conduct."

Because all three inmates committed suicide by affixing shoelaces and bed sheets to the ventilation grilles in their cells, the warden asked the prison industry program to create "safety gowns and blankets" made of tightly woven fabric that resists tearing. Slippers or footwear without laces will be distributed to all inmates in high-security housing units. Installation of closed circuit television monitoring of suicidal inmates, redesign of ventilation grilles, and more frequent and random security rounds by correctional staff are also being considered. Additional suicide prevention training has recently been provided to staff.

Warden Mahoney said he will also seek federal funding to study possible alternatives to placing mentally ill inmates in the prison. He believes it could have made a difference for Kevin Osmanson. "If he would have been in a facility that was more of a hospital, intervention and other strategies may have been used to prevent it," the warden stated.

Oregon

On his 70th day in solitary confinement, Billy Owens erupted into a psychotic fit and died at the hands of prison officers. An Oregon State Police investigation determined his death by asphyxiation was an accident.

But a report by a federally funded watchdog group says Owens, who suffered from severe schizophrenia, was the victim of a prison system that failed to adequately care for and monitor him. "The prisons are now the state's largest mental health facilities," said Robert Joondeph, the Oregon Advocacy Center's executive director. "But they're taking us back decades, if not centuries, in terms of how we treat people with mental illness, which is to isolate and punish them."

The center's investigation also found serious defects with the state Department of Corrections' efforts to treat and manage the growing number of mentally ill inmates. Among other things, the group called for changing "inhumane, unjust and ineffective" policies of punishing mentally ill inmates by isolating them in disciplinary segregation.

Owens was frequently in the disciplinary segregation unit of the Snake River Correctional Institution in Ontario. On April 29, 2002, he began stabbing himself in the neck with a broken pen, prompting officers to blast him three times with pepper spray. Eventually, five officers in riot gear dragged him out of his cell and restrained him with his face to the floor, where he stopped breathing. As Owens, 45, lay dying, according to the Corrections Department's review, prison staff laughed and engaged in unrelated banter. A nurse kissed an officer. Someone asked for a round of applause for the person trying to revive Owens.

With 22 percent of Oregon's 12,200 inmates suffering from serious mental illness, officials have said they are growing more concerned about state prisons becoming de facto mental institutions. But officials would answer only a few questions about the report and said discussing it might violate medical confidentiality laws. Perrin Damon, a department spokeswoman, said the agency is constantly looking for better ways to care for mentally ill inmates. She said the department is taking the report's recommendations seriously.

Before his death, Owens had served 12 years in prison for trying to kill his grandmother during a bout of psychosis. He was convinced that an evil intruder inhabited her body. In prison, his mental illness was far from secret. He was admitted to the Oregon State Hospital and psychiatric units several times, only to be treated and returned to prison life. His final stay in the Oregon State Penitentiary's 40-bed psychiatric unit lasted from September 2000 to April 2001.

The Oregon Advocacy Center's report was highly critical of the Corrections Department repeatedly punishing Owens with long periods in solitary confinement whenever delusions from his mental illness led to violent outbursts. Disciplinary segregation prisoners spend 23 hours a day isolated in a cell with only limited possessions. Among other things, Owens suffered repeated hallucinations of a plot to harm his family and friends on the outside. "He heard the television, inmates and staff talking about plans to harm or torture his family," the review found.

In February 2002, Owens started a 145-day sanction in the unit for starting a fight with his cellmate. As part of its investigation, the Oregon Advocacy Center obtained a security camera video of the confrontation between Owens and the corrections officer. On each of the three days before his death, Owens had refused to take his medications. The night before, he punched his cell window until his knuckles were bloody, and he kicked his door through the night.

In its written response to the Oregon Advocacy Center, the Corrections Department said that the officers followed proper procedures, that Owens faked being unconscious before jumping up from the cell floor and repeatedly stabbing himself in the neck with the pen, and that he also refused to follow verbal orders and put up a struggle. "This pattern presented a particular danger to the staff," the department said.

Attempts to resuscitate Owens didn't begin for several minutes after he stopped breathing. Officers, the letter explained, were slow to help the inmate because they weren't sure if he was feigning unconsciousness. Staff members then had trouble finding a mask to begin mouth-to-mouth resuscitation, the department said. The autopsy found that Owens died of "restraint asphyxiation in excited delirium and/or restraint syndrome preterminal positional asphyxiation."

The Oregon Advocacy Center is urging the state to move away from segregation and toward more clinical therapy if an inmate's disruptive behavior stems from mental illness. Because solitary confinement agitates many mental illnesses, 15 days should be

the maximum punishment and only after all alternatives have been exhausted, the report states. The group said the Corrections Department should make use of padded rooms and follow the reforms of other states when it comes to officers restraining unruly prisoners in the prone position on the ground. It also recommends better training for officers, especially in the areas of first aid, and in identifying symptoms of emotional and mental disorders.

Besides the family, the state notified only the newspaper in Ontario about the death. Joondeph said his group became aware of it after receiving a letter from another group. "We knew this wasn't going to come to light any other way," he said. "The more we found, the more we felt we needed to a do a thorough report."

The above article — "Watchdog Group Raises Alarm Over Inmate's Death" — was written by Joseph Rose, a staff writer for ***The Oregonian****. It appeared in the November 20, 2003 edition of the newspaper and is reprinted with the permission of* ***The Oregonian****.*

The Oregon Advocacy Center's ***Report of a Review of the Mental Health Treatment, Restraint and Death of James Owens in the Oregon Correctional System*** *(September 2003) is available from the Oregon Advocacy Center, 620 S.W. Fifth Avenue, 5th Floor, Portland, Oregon 97204 (503/243-2081), www.oradvocacy.org*

Ohio

Christopher Dawson was found hanging from a bed sheet in his protective custody cell at the Licking County Jail in Newark on September 15, 2003. The 19-year-old student at the University of Toledo had been arrested two days earlier and charged with the rape of a fellow college student. Soon thereafter, correctional officer Jason Hill was placed on administrative leave due to a suspicion that he failed to conduct his required cell checks in the housing unit, as well as falsified jail logs.

Following a 15-day internal affairs investigation of the suicide, Mr. Hill was terminated from the Licking County Sheriff's Office. "Upon review, we felt he lacked in the performance of his duties, so we took what we felt was the appropriate action," sheriff's department spokesman Colonel Randy Thorp told *The Newark Advocate*. "We don't shy away from an issue that we may have if we have an issue. We thoroughly investigate it and deal with it in the appropriate manner. In this case, it was termination."

On October 10, 2003, former correctional officer Jason Hill was criminally charged with one count of falsification, a first degree misdemeanor, and one count of dereliction of duty, a second degree misdemeanor. A trial date is pending.

Arkansas

On September 2, 2003, county prosecutors released findings from an investigative report that cleared several Benton County Jail deputies of criminal wrongdoing in the death of inmate Donald Winter. Mr. Winter had died from an infection while suffering a psychotic breakdown on January 1, 2003. The investigation by Benton County prosecutors and the Arkansas State Police also relieves Bates Hospital in Bentonville of criminal negligence, chief deputy prosecutor Van Stone told the *Arkansas Democrat-Gazette*. But it does not address potential civil liability on the part of jail staff or the hospital. Phillip Votaw, an attorney representing Mr. Winter's family, told the newspaper that he will study the report to determine "who to sue."

In the hours before his death, Donald Winter's demeanor deteriorated from loud, delirious thrashing in his jail cell, to taking face-first falls onto the concrete floor, to listless grunting. Bates Hospital (now Northwest Medical Center of Benton County) treated Mr. Winter for dehydration and conducted blood tests the day before his death at the request of the sheriff's department. Yet according to reports, hospital staff refused to admit Mr. Winter for treatment, citing his violent and combative behavior.

With no beds available at the state mental hospital, Mr. Winter was returned to the Benton County Jail in Bentonville. "We did everything humanly possible to help Mr. Winter," Sheriff Keith Ferguson told the *Arkansas Democrat-Gazette*. "The hospital refused to take him. There wasn't a mental facility to take him. I hate that this happened, but we're not a hospital or a mental ward. We don't have the facilities to care for psychiatric patients."

The state medical examiners office ruled that the 60-year-old inmate died of peritonitis, or swelling and eventual bursting of a membrane that lines the stomach cavity. The condition was due to a perforated ulcer. The peritonitis was accompanied by multiple blunt-force injuries on Mr. Winter's head, torso, arms and legs, along with fractured ribs, according to the medical examiner's report.

State police investigator Bill Baskin wrote in an investigative summary that Benton County Jail staff observed Mr. Winter striking his chin, head, elbows and legs on the metal toilet in his cell during his five days in jail. Associate Medical Examiner Stephen Erickson ruled that Mr. Winter's injuries were consistent with self-inflicted injuries, or those caused by restraints. Dr. Erickson also said that with proper medical attention, the inmate would not have died from the perforated ulcer.

Donald Winter was arrested on December 28, 2002 for criminal trespass and booked into the Benton County Jail. Two days later on December 30, Circuit Judge John Scott ordered him to be civilly committed to the state hospital for a psychiatric evaluation. With no beds available, he languished in the county jail. Mr. Winter, who had a long history of mental illness with a diagnosis of bi-polar disorder and paranoid schizophrenia, struggled often with deputies and was placed in restraints several times over a three-day period. While in the jail, he refused food and most water, saying it was laced with acid.

CORRECTION

On pages 18 and 19 of the Spring 2003 issue of the ***Jail Suicide/Mental Health Update*** (Volume 12, Number 1), we incorrectly identified an inmate suicide as having occurred in the "Richland" County Jail in Augusta, Georgia. The suicide actually occurred in the Richmond County Jail in Augusta, Georgia. We regret the typographical error.

A jail deputy found Mr. Winter unresponsive on the floor of his jail cell at approximately 4:15 pm on January 1, 2003. Back-up personnel were summoned and initiated cardiopulmonary resuscitation. Paramedics arrived approximately 15 minutes later and found that Mr. Winter's body was showing signs of both lividity and rigor mortis. Investigators could not determine when Mr. Winter was last observed by jail staff, but estimated that it was much greater than 60 minutes.

Donald Winter had been housed in a detoxification cell near the booking area so that he could be more frequently observed by staff. The cell was equipped with closed circuit television (CCTV) monitoring. Reports indicated that deputies first checked on Mr. Winter at approximately 7:45 am. He was lying on his back and waving his hands in the air. At 8:45 am, Mr. Winter was asleep on the floor of his cell. Deputies did not serve him any lunch at 10:45 am because he was sleeping. At noon, deputies placed a sheet over the window in Mr. Winter's cell because he had refused to stop standing on a bench and masturbating. Despite the presence of the sheet, the deputies claimed they could still see the inmate through a small window in his cell door and via the CCTV monitor.

At approximately 2:00 pm, a deputy monitoring the CCTV observed Mr. Winter take a hard fall. He sent another deputy to the cell. The deputy looked into the cell and saw the inmate breathing, but not moving. "He was naked, and he was leaning over, on his knees, head down with rear up in air," the deputy wrote in a report. "I was watching his sides to see if he was breathing. He seemed to be all right." Some time later (jail staff claimed it was approximately 3:45 pm, although medical evidence regarding the lividity and rigor mortis of Mr. Winter's body would seem to call into question such a time frame), the deputy monitoring the CCTV observed Mr. Winter fall again. A deputy went into the cell and asked Mr. Winter if he was in distress. The inmate only grunted and the deputy left the cell area.

Benton County Attorney Robin Green told the *Arkansas Democrat-Gazette* that she would review the death investigation to determine possible civil claims against the county, as well as any corrective action at the Benton County Jail.

West Virginia

The neighbor of an inmate who hanged himself with a bed sheet in the Cabell County Jail in Huntington said she told 911 dispatchers that the man was suicidal when she made the initial call that led to his arrest. The 911 call is part of an internal investigation launched by the Cabell County Sheriff's Department to determine whether 33-year-old Neil G. Koster gave any indication to deputies or jail personnel that he was suicidal. "If we determine through the investigation that suicidal tendencies were prevalent, then we are going to take action within," Chief Deputy Jim Scheidler told *The Herald-Dispatch* on August 22, 2003.

According to police reports, Neil Koster was arrested near his home during the late evening of August 17, 2003 for driving on a suspended license and no proof of insurance. He was transported to the county jail, processed, and housed in the day room area. A correctional officer found Mr. Koster hanging from the bars that surround the day room a few hours later. He was transported to a local hospital and died a short time later.

Charlene Wilson, who lived in the neighborhood, said she called 911 shortly after Mr. Koster's arrest at the request of his wife. Ms. Wilson told *The Herald-Dispatch* that said she saw Neil Koster earlier in the evening throwing things out of his trailer and heard him threatening suicide. "I had never seen him that way," Ms. Wilson stated. "He told me that he didn't want to live anymore, and that he wanted to die." Ms. Wilson said she called 911 and told a dispatcher that Neil Koster was suicidal and needed help. "Patricia Koster asked me to call 911 because she was too shook up to do it," Ms. Wilson said. "She told me to tell them that Neil is trying to kill himself and that he tried it once before three years ago. I did exactly what she asked me to do because she was begging for help."

Sheriff's department investigators have interviewed the 911 dispatcher, deputies, jail personnel, and an inmate who was in the day room area with Neil Koster. According to police reports, Mr. Koster told the inmate that he wanted to go to the state hospital. The inmate paid no attention to Mr. Koster and fell asleep, according to the report. "When the investigation is complete, we'll have a better idea if policies and procedures need to be changed or upgraded," Sheriff Kim Wolfe said.

Mississippi

On December 18, 2003, the U.S. Justice Department announced that it had filed a federal lawsuit challenging the conditions of confinement at two state juvenile institutions — the Oakley Training School in Raymond and Columbia Training School in Columbia. The Oakley facility houses approximately 325 boys ranging in age from 10 to 18, while the Columbia facility holds approximately 100 boys ages 10 to 15, as well as 100 girls ages 10 to 18. The majority of these youth are non-violent offenders. The lawsuit, filed in the U.S. District Court for the Southern District of Mississippi, alleged that conditions at these facilities routinely and systemically deprived juveniles of federally protected civil rights.

"The conditions at Oakley and Columbia are unconscionable," R. Alexander Acosta, Assistant Attorney General for the Civil Rights Division, stated in a press release. "This is no way to set juvenile offenders on the course to law abiding and productive lives. Such children are among the most vulnerable in our society, and this Administration is firmly committed to the vigorous protection of their rights."

The lawsuit follows a year-long investigation by the Justice Department's Civil Rights Division, Special Litigation Section. The findings were previously detailed in a 48-page report sent to the governor and attorney general in June 2003. That report documented evidence of numerous civil rights violations, including staff violence and abusive institutional practices, unreasonable use of isolation and restraints, and inadequate medical, mental health, and educational services.

The investigation revealed evidence that youth were frequently subjected to physical abuse by staff, routinely shoved and hit, "hogtied" with hands and feet bound together behind their backs, as well as "pole-shackled" with hands tied behind a pole and left on public display for hours at a time. According to the lawsuit,

direct care staff made liberal use of pepper spray — even spraying juveniles already in restraints. Punitive "exercise programs" included forcing youth to exercise carrying tires around their bodies or mattresses on their backs, and when some girls were ill as a result of running in the heat, reports indicated that they were forced to eat their own vomit.

The Justice Department also found grossly inadequate and punitive suicide prevention practices at both institutions. At the Oakley facility, boys on suicide precautions were "placed in an empty day room adjacent to the control room where they sit on the floor all day without access to books, school, or outdoor exercise. They are not permitted to interact with other boys in the room." Worse conditioms were found at the Columbia facility where girls identified as either suicidal or behavioral problems were placed in a cell called the "dark room." According to Justice Department's report:

> "The 'dark room' is a locked, windowless isolation cell with lighting controlled by staff. When the lights are turned out, as the girls reported they are when the room is in use, the room is completely dark. The room is stripped of everything but a drain in the floor which serves as a toilet.
>
> Most girls are stripped naked when placed in the 'dark room.' According to Columbia staff, the reason girls must remove their clothing before being placed in the darkroom is that there is metal grating on the ceiling and the cell door which could be used for hanging attempts by suicidal girls…"

Out-going attorney general Mike Moore has complained that the Justice Department insisted on settling the matter with a enforceable consent decree rather than a letter of agreement that would have given the state more autonomy. The lawsuit is a waste of taxpayer money, he told *The Clarion-Ledger*. "Unfortunately, instead of spending hundreds of thousands of dollars improving the lives of their children, Mississippi and the federal government will be spending hundreds of thousands of dollars paying lawyers, which is ridiculous."

Assistant Attorney General Acosta countered by stating in a separate press release that "since we issued that report (in June), Mississippi officials have taken some important first steps toward reform. Our attorneys have met and spoken with Mississippi officials. Despite some initial progress, we have been unable to obtain agreement on an in-court settlement. Given the nature and the pattern of the violations identified, we believe that a remedy backed by the authority of the federal judiciary is necessary to effect lasting and systemic change. We do not lightly seek to place state facilities under consent decrees, but believe that one is necessary in this case."

The U.S. Justice Department's 48-page findings letter to Mississippi Governor Ronnie Musgrove is available at www.usdoj.gov/crt/split/documents/oak_colu_miss_findinglet.pdf. Additional information about the Special Litigation Section of the Justice Department's Civil Rights Division can be found at www.usdoj.gov/crt/split/index.html. ❑

JAIL SUICIDE/MENTAL HEALTH UPDATE

This technical update, published quarterly, is part of the National Center on Institutions and Alternatives (NCIA)'s continuing efforts to keep state and local officials, individual correctional staff, mental health/medical personnel, and interested others aware of developments in the field of jail suicide prevention and jail mental health services. Please contact us if you are not on our mailing list. Readers are encouraged to offer opinions and/or submit pertinent materials for inclusion into future issues.

This publication is supported by Cooperative Agreement Award Number 03J31GIZ6 from the National Institute of Corrections (NIC), U.S. Department of Justice. Points of view or opinions stated in this document do not necessarily represent the official position or policies of the U.S. Department of Justice.

Unless otherwise noted, all articles appearing in this newsletter are written by Lindsay M. Hayes, Editor/Project Director.

AVAILABLE JAIL/PRISON SUICIDE PREVENTION MATERIALS

And Darkness Closes In...National Study of Jail Suicides (1981)
National Study of Jail Suicides: Seven Years Later (1988)
Training Curriculum on Suicide Detection and Prevention in Jails and Lockups—Second Edition (1995)
Curriculum Transparencies—Second Edition (1995)
Prison Suicide: An Overview and Guide to Prevention (1995)
Jail Suicide/Mental Health Update (Volumes 1 through 11)

For more information regarding the availability and cost of the above publications, contact either:

Lindsay M. Hayes, Editor/Project Director
National Center on Institutions and Alternatives
40 Lantern Lane
Mansfield, Massachusetts 02048
(508) 337-8806 • (508) 337-3083 (fax)
Web Site: www.ncianet.org/cjjsl.cfm
E-Mail: Lhayesta@aol.com

or

NIC Information Center
1860 Industrial Circle, Suite A
Longmont, Colorado 80501
(800) 877-1461 • (303) 682-0558 (fax)
Web Site: www.nicic.org