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)

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A Jail Cell, Two Deaths, and a Telephone Cord

Port Isabel, Texas is a small, picturesque village on Laguna Madre, the body of water between the mainland and South Padre Island, a popular vacation area for college students during Spring break. The city of less than 7,000 year-round residents is located near the southern most tip of Texas, approximately 30 miles north of the Mexican border. The city jail, containing four single cells and a large holding cell, is located inside the Port Isabel Police Department.

Rolando Domingo Montez

On November 14, 1999, Rolando Domingo Montez had spent his 19th birthday celebrating with two friends on South Padre Island. Upon returning to Port Isabel, they stopped by a friend's house and, finding no one at home, decided to wait by sitting on a boat at the next door neighbor's house. Soon thereafter, the boat owner came outside, began yelling at the youths, and threatened to call the police. Mr. Montez and his friends left the property and began to drive home. At approximately 11:30pm, their car was pulled over by officers of the Port Isabel Police Department. There had been several burglaries in the area and Mr. Montez and his friends seemed to fit descriptions of the suspects. Although not charged in the burglaries, he was arrested for public intoxication and criminal trespass, transported to the Port Isabel Police Department, and booked into the city jail. According to officers, Mr. Montez appeared nervous, but cooperative.

Rolando Montez's criminal history was limited to an arrest the previous year for possession of marijuana for which he had been confined overnight in the city jail. Mr. Montez had recently withdrawn from high school due to poor grades and attendance, but maintained part-time employment at a local restaurant. He was recently estranged from his common-law wife. The couple had a 17-month-old son. According to family members, Mr. Montez did not have a history of either mental illness or suicidal behavior.

Following the booking process, Mr. Montez was placed in Holding Cell No. 1. The six-by-ten-foot cell contained a concrete bed, stainless steel sink and commode, and a telephone mounted on the wall with a 19-inch metal cord. A closed circuit television (CCTV) camera was mounted in the corridor on a wall and pointed toward the cell door. However, most of the cell interior, including the telephone, was outside the view of the CCTV. The Port Isabel Police Department did not have any personnel assigned to the jail facility, and relied on its police officers to periodically check the cellblock when they escorted detainees to and from the area. The CCTV monitor was located in the communications dispatcher's office and, although this individual was responsible for "periodic prisoner checks every 10 minutes," they were prohibited from leaving the communications area. Thus, the dispatcher performed their detainee supervision duties by periodically looking into a monitor with an obstructed view of the cell interior.

Mr. Montez was arraigned in court the following afternoon (November 15) and bond was set at $1,200 for the two misdemeanant charges. He was transported back to the city jail. At approximately 6:00pm, he called his mother, Pearl Garza, and said, "Mom, I'm in jail." She responded, "Oh Rolando, again? What are you in for?" Mr. Montez responded, "I was out partying with friends and we all got arrested. Mom, you have to get me out of here." Mrs. Garza promised her son that she would try to raise the money for bond. Mr. Montez called his mother again at approximately 8:30pm and inquired about the bond money. He appeared anxious and informed his mother that if he did not get bailed out soon he would be transferred to the county jail. Mrs. Garza responded, "Well, I'll try and see if I can do something to get you out." Her son called her again 10 minutes later and said," Mom, I remember, go and talk with Dora (his mother-in-law). I know Dora will help me…Please, Mom. Call her. I know she will help you. I know you don't have the money, but I know she can help you." Mrs. Garza responded, "Okay, I'll call her." Her son, who now appeared scared and on the verge of tears, then said, "Mom, I'm going to die…" and they were cut off. Mrs. Garza continued calling family members trying to raise enough money for her son's bond. She then called the judge who had set the

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bond. He was a friend of the family and agreed to reduce the bond the following morning.

Mrs. Garza arrived at the Port Isabel Police Department the following morning (November 16) and inquired about the legal status of her son. Detective Tomas Salazar talked with Mrs. Garza, informed her of the charges and the fact that Rolando would be released on personal recognizance later that afternoon (at 5:00pm) because the Cameron County Jail was not available for housing misdemeanant detainees. According to Detective Salazar, Mrs. Garza was still concerned about her son following their telephone conversation the night before and she told the detective that her son "felt that he was going to die because of all the things that were happening to him." Detective Salazar tried to comfort Mrs. Garza and told her, "I'll talk to him. Leave it to me. I'll talk to him and see what's going on."

Martin Rodriguez arrived to start his shift as the communications dispatcher at approximately 1:45pm. There were three inmates in facility, including Mr. Montez. According to the dispatcher, Mr. Montez yelled out for Detective Salazar several times during the next two hours. Although no one responded to his repeated requests, Mr. Montez could be seen periodically on the monitor to be either standing at the cell door or sitting on his bunk. At approximately 4:30pm, a friend of Dispatcher Rodriquez arrived at the police station. He was a volunteer fireman who worked next door. The two friends socialized in the dispatcher's office and watched a television program.

Mrs. Garza returned to the Port Isabel Police Department at approximately 4:45pm to pick up her son. She asked Dispatcher Rodriguez if she could speak with Detective Salazar and was informed that the detective would be with her shortly. According to Mrs. Garza, the dispatcher appeared distracted, watching a television show and laughing with his friend. According to Dispatcher Rodriquez, he looked up at the CCTV monitor and observed Mr. Montez sitting on the bench in Holding Cell No. 1. The time was now 5:00pm. At approximately the same time, Detective Salazar received a telephone call from a neighboring police department requesting assistance in following a suspicious vehicle that was heading toward Port Isabel. Detective Salazar and another detective (Daniel Marchan) subsequently left the building without talking with Mrs. Garza.

> "Go ahead and sue us.
> The phones are not going in."

Both detectives returned to the Port Isabel Police Department at approximately 5:28pm. A few minutes later, Detective Marchan was escorting an arrestee into Holding Cell No. 1 when he opened the cell door and observed Mr. Montez hanging from the metal cord of the telephone. The 19-inch cord was looped around his neck with the receiver resting in the cradle of the telephone. The detective yelled out for assistance and other officers responded to the cell. They removed Mr. Montez's body from the telephone cord and initiated chest compressions. Although certified in cardiopulmonary resuscitation (CPR), none of the officers initiated mouth-to-mouth resuscitation on the victim apparently because protective equipment (e.g., a micro shield, pocket mask, Ambu Bag, etc.) was not available. The paramedics were called and subsequently arrived to initiate CPR. Mrs. Garza, who was still impatiently sitting in the lobby of the police station awaiting the release of her son, sensed that something was terribly wrong back in the cellblock area. A short time later, Police Chief Joel Ochoa came out to the lobby and informed Mrs. Garza that her son had hung himself and was being airlifted by helicopter to the hospital. Rolando Montez was pronounced dead at 6:30pm on November 16, 1999.

Within hours of the death, an investigator from the Texas Rangers arrived at the Port Isabel Police Department to begin an investigation. The investigator recommended to Chief Ochoa that the telephones be removed from each of the five cells. All the telephones were removed the following morning. End of story? Not at all.

Since February 1998, JCW Electronics, Inc. had enjoyed an exclusive five-year contract with the Port Isabel Police Department to install and operate telephones within the city jail. (The contract also included installment of CCTV equipment in two cells.) When the telephone equipment was initially installed inside each cell, it was thought to be mutually beneficial to both the police department and JCW Electronics. Allowing a detainee unlimited access to the telephone in their cells meant police officers did not have to respond to frequent requests for telephone use nor spend time escorting a detainee to and from their cell. Placement of the equipment inside the cell also meant that the detainee would presumably make more collect telephone cells, resulting in more profits for JCW Electronics. When the telephones were removed from the cells on November 17, 1999, JCW Electronics was no longer making money on its contract with the Port Isabel Police Department.

On December 10, 1999, a meeting was held in the office of John Haywood, attorney for the City of Port Isabel. In attendance were Bradley and Jerry Woods, owners of JCW Electronics, Inc.; Keith Mayo, attorney for JCW Electronics; Police Chief Joel Ochoa; and City Manager Robert Garcia. According to the participants, the suicide of Rolando Montez, as well as a wrongful death lawsuit recently brought by his mother, were initially discussed. What occurred after that point remains in dispute. According to Attorney Haywood, the real purpose of the meeting was that "Mr. Woods wanted to get the phones back into the cells. He expressed that we had a contract, that he wanted the city to abide by the contract, that he was losing revenue and wanted the phones reinstalled." Sensing that legal action was being threatened if the telephones were not reinstalled, Mr. Haywood informed both Bradley Woods and Attorney Mayo to "Go ahead and sue us. The phones are not going in." He also asked Mr. Woods if he had ever heard of an inmate utilizing a telephone cord to attempt suicide and was told that "JCW Electronics had never experienced a similar suicide using their phones, but….that there had been similar suicides in North Texas with Southwestern Bell and GTE phones." Attorney Haywood and the two other city officials expressed anger that they had not been notified earlier that such an incident was possible.

Despite an initial insistence that the telephones would not be reinstalled, the city officials listened to Mr. Woods' suggested alternative that the telephone cords could be shortened from 19- to 8-inches in length. According to City Manager Garcia, the

representatives of JCW Electronics "assured us that it would be impossible for anybody to hang themselves with the cords at 8 inches or less. The decision to keep the phones in the cells was based on that assurance."

Bradley Woods saw the meeting differently, claiming that neither he nor Attorney Mayo ever threatened to bring a breach of contract lawsuit against the city. According to Mr. Woods, "The only discussion we had was the installation of the shorter cord as an option." He also denied that he had guaranteed the safety of the telephones or that it would be impossible for an inmate to hang themselves with a shortened cord — "I don't see how I can guarantee prisoner safety. I'm not there. I'm not watching them. I'm not in control of them." Mr. Woods and his attorney also denied that, prior to Rolando Montez's death, they were aware of other inmate suicides utilizing telephone cords.

Where there was agreement, however, was in the fact that, immediately following the meeting of December 10, 1999, Bradley Woods walked across the street to the Port Isabel Police Department and reinstalled each of the telephones with shortened 8-inch metal cords.

Gavino Barrera

Gavino Barrera was only 18-years-old when he married 26-year-old Maria De Lourdes in 1994. The couple had three young children and lived in Port Isabel. Gavino was employed in the shrimp business as a fisherman, while Maria worked in a hotel as a housekeeper. The couple had met three years earlier, fallen in love, and enjoyed a tranquil relationship during the early years of marriage. However, shortly after the birth of their third child in 1997, Mr. Barrera began to drink excessively. When drinking, he would act irrationally, accusing his wife of having an extra-martial affair. During these bouts of drinking, Mr. Barrera also began verbally and physically assaulting his wife. Officers from the Port Isabel Police Department were called to the home on several occasions and Mr. Barrera was detained in the city jail various times for domestic violence and public intoxication. Eventually, in late 1997, when the excessive drinking and abuse would not stop, Maria Barrera filed for legal separation.

In June 1998, Mr. Barrera came to his wife's home and asked to visit with his children. Although he had been drinking, Mrs. Barrera thought it a good idea for the children to visit with their father. She allowed him into the house. Several minutes later, however, Mr. Barrera walked out of the kitchen brandishing two knifes. He threatened to kill his family and then himself. Maria Barrera immediately ran to a neighbor's home and called the police. Mr. Barrera was arrested, transported to the city jail, and placed in a holding cell. Shortly thereafter, a dispatcher looked at the CCTV monitor and observed Mr. Barrera attempting to hang himself by wrapping a shirt around his neck and tying it to the cell door. Police personnel responded to the cell and prevented Mr. Barrera from causing any injury. He was released from custody shortly thereafter.

During the next several months, Gavino Barrera attempted to reconcile with his wife by promising to stop drinking. But the drinking and abuse continued, and Mrs. Barrera eventually obtained a protective order against her husband in June 1999.

At approximately 2:00pm on December 25, 1999, Gavino Barrera went over to his wife's house with three bicycles he had bought the children for Christmas. He appeared friendly and had not been drinking. Despite the protective order, Mrs. Barrera invited him into the house to visit with the children. He left several hours later without incident. At around 8:00pm, Mr. Barrera returned with four friends. They all had been drinking. Mrs. Barrera called the police when her husband would not leave the residence. Prior to the arrival of police, Mr. Barrera left the house and began walking up the street toward a local bar. He was stopped by officers of the Port Isabel Police Department soon thereafter. Although appearing cooperative, he was unsteady on his feet and obviously intoxicated. Gavino Barrera was arrested on charges of public intoxication and violation of the protective order. He was transported to the city jail.

NOW AVAILABLE:
JUVENILE OFFENDERS WITH MENTAL DISORDERS

Lisa Melanie Boesky, Ph.D., a well-respected adolescent psychologist with considerable experience working with juvenile offenders, has recently authored *Juvenile Offenders with Mental Disorders: Who Are They and What Do We Do With Them?* The 342-page treatise provides authoritative, practical guidance to effective management and treatment of juvenile offenders. Its 16 chapters are divided as follows: 1)Youth with Mental Health Disorders in the Juvenile Justice System; 2) The Diagnosis of Mental Health Disorders; 3) Oppositional Defiant Disorder and Conduct Disorder; 4) Mood Disorders: Major Depression, Dysthymic Disorder and Bipolar Disorder; 5) Attention-Deficit/Hyperactivity Disorder; 6) Post-Traumatic Stress Disorder; 7) Developmental Disorders: Mental Retardation, Learning Disabilities and Fetal Alcohol Syndrome; 8) Schizophrenia and Other Psychotic Disorders; 9) Substance Use Disorders: Substance Abuse Disorders and Substance Dependence; 10) Co-Occurring Mental Health and Substance Abuse Disorders; 11) Suicidal Behavior Among Juvenile Offenders; 12) Self-Injurious Behavior Among Juvenile Offenders; 13) Screening and Assessment of Juvenile Offenders with Mental Health Disorders; 14) Treatment of Juvenile Offenders with Mental Health Disorders; 15) Special Issues I: Minority Youth, Female Offenders, Homosexual Youth; and 16) Special Issues II: Head Trauma/Neuropsychiatric Factors, Violence and Mental Illness, Seclusion and Restraint, Malingering, Staff Training.

For more information regarding the availability of *Juvenile Offenders with Mental Disorders: Who Are They and What Do We Do With Them?*(2002), contact the American Correctional Association, 4380 Forbes Boulevard, Lanham, Maryland 20706, (800/222-5646).

During the booking process, Mr. Barrera became despondent, upset that he would be spending Christmas evening in jail. He told arresting Officer Jorge Vasquez that he "was tired of the way he was living" and "would hurt himself" if placed in a holding cell. Concerned by the comment, Officer Vasquez alerted his supervisor, Officer Hector Martinez, who talked briefly with Mr. Barrera. The detainee repeated his threat and Officer Martinez warned Mr. Barrera that he would be stripped naked and placed in a cell for threatening suicide. Mr. Barrera then replied that he was merely joking and did not intend to commit suicide. Although both Officers Vasquez and Martinez were familiar with Gavino Barrera and aware that he had threatened suicide during prior interactions with the police department, his jovial appearance on that day did not concern them enough to believe that he was at risk for suicide. Mr. Barrera was placed in Holding Cell No. 1 at approximately 9:00pm.

Gabriella McDowell was also familiar with Gavino Barrera. She worked as a communications dispatcher at the Port Isabel Police Department and remembered Mr. Barrera had previously either threatened or engaged in suicidal behavior when intoxicated during previous stays in the city jail. According to Dispatcher McDowell, "I remember one time when Mr. Barrera was arrested and jailed, he immediately attempted to commit suicide by taking his shirt off and tied it to the jail door, but he was stopped before he could do any harm to himself."

"I checked the monitor frequently...and I couldn't see him. I thought he was in the corner sleeping. Since he was quiet, I thought he had just fallen asleep."

Ms. McDowell was working as the communications dispatcher when Mr. Barrera was placed in Holding Cell No. 1 on December 25, 1999. Pursuant to the policy manual, the communications dispatcher "keeps radio logs, answers phones, dispatches calls for police, fire and ambulance services, meets complainants, and performs related work as required." According to Dispatcher McDowell, "Part of my job description is to also check on the prisoners by viewing the monitors. I am not allowed to leave the dispatch area and physically check on the prisoners." In regard to checking on Mr. Barrera after he was placed in the cell around 9:00pm, she stated that "I checked the monitor frequently…and I couldn't see him. I thought he was in the corner sleeping. Since he was quiet, I thought he had just fallen asleep."

About an hour later during the 10:00pm shift briefing, Officer Ronald Moore was informed that Mr. Barrera was in custody. Officer Moore, who also had knowledge of the prior suicide attempt by Mr. Barrera in June 1998, asked his colleagues if the detainee had been drinking and threatening suicide during the booking process, to which Officer Martinez replied, "I don't know, I think so." Officer Moore then requested that Officer Salvador Cabrera begin to make checks of the cells, including Holding Cell No. 1. When Officer Cabrera initially walked up to Holding Cell No. 1, Mr. Barrera was not visible through the small window of the cell door. The officer continued to walk by and checked the remaining cells.

Upon his return past Holding Cell No. 1 a few minutes later, Officer Cabrera again looked through the window and still could not see Mr. Barrera, but did notice a piece of clothing hanging in the corner of the cell. The officer then walked back to the sergeant's office and inquired as to which cell Mr. Barrera was housed. Officer Cabrera then returned to Holding Cell No. 1 and when the cell door was opened a few minutes later at approximately 10:14pm, Gavino Barrera was discovered hanging from the metal cord of the telephone in his cell. Officer Cabrera yelled out for assistance and other police department personnel responded to the cell. They removed Mr. Barrera's body from the telephone cord and initiated CPR. The paramedics were called and subsequently arrived to continue life-saving measures. Mr. Barrera was then transported by helicopter to a hospital where he was pronounced dead.

City Attorney John Haywood had been sitting in his office when he heard a helicopter flying overhead. He immediately thought back to a few weeks earlier and the Montez suicide. He had an uneasy feeling that something similar had just occurred. His fears were confirmed a few minutes later when Police Chief Joel Ochoa called and informed him of the Barrera incident. Chief Ochoa also placed a telephone call that night to Rolando Castaneda of the Texas Rangers. Sergeant Castaneda had been the lead investigator in the Rolando Montez suicide. Chief Ochoa informed the investigator that there had been another suicide at the jail by use of a telephone cord. "You've got to be kidding," said Sergeant Castaneda. "No, I'm not kidding," responded the chief. Just 39 days removed from the death of Rolando Montez, a second suicide had occurred in Holding Cell No. 1 of the Port Isabel Police Department. One cell, two deaths, and a telephone cord. The telephones were again removed the cells in the city jail.

The Montez Trial

Following the death of her son, Pearl Garza filed a wrongful death lawsuit in the 107th Judicial District Court of Cameron County, Texas. The defendants were the City of Port Isabel, JCW Electronics, Inc., and Quadrum Telecommunications, Inc., the manufacturer of the telephones used in the city jail. According to *Garza v. City of Port Isabel, et. al.* (Cause No. 99-11-4765-A), as a direct and proximate cause of negligence:

> "…the City of Port Isabel failed to supervise the jail section, in particular the jail cell occupied by the decedent….The City of Port Isabel and those described herein are liable for the death of Rolando Domingo Montez as a direct and proximate result of a condition or use of tangible or real property. The decedent was found hung by a phone cord connected to a phone in the decedent's jail cell, which was supposed to be monitored by the employees of the City of Port Isabel….JCW Electronics, Inc. failed to use ordinary care, that is failing to do that which a company of ordinary prudence would have done under same or similar circumstances, in that they failed to modify or make available a phone and

accompanying system that was appropriate or in good working order for jail cell use…JCW Electronics, Inc. represented that the jail cell phone and accompanying system was safe for unattended use by inmates….Quadrum Telecommunications, Inc. designed, manufactured, installed and along with JCW Electronic, Inc. marketed a defective product, that being the jail cell phone and accompanying system that was unreasonably dangerous to the user, or Plaintiff in this case, and that product caused physical harm and the eventual death of Rolando Domingo Montez…"

During the discovery phase of the case, experts for both the plaintiff and defendants lined up to give their opinions. The plaintiff's expert, a national consultant specializing in field of jail suicide prevention, offered the following opinions:

1) Rolando Montez's potentially suicidal statement was either dismissed or ignored by Port Isabel Police Department personnel (i.e., Detective Salazar's acknowledged that Mrs. Garza "*told me that her son had told her that he felt that he was going to die because of all the things that were happening to him*.") There is no information to suggest that Detective Salazar took any action to safeguard the decedent, either by placing him on suicide precautions, questioning the decedent regarding his suicidal statements, and/or referring Mr. Montez to either the local hospital or a mental health professional for assessment;

2) Intake screening is a basic staple of jails and police department lockup facilities throughout the country and is advocated by all national correctional standards. Contrary to this standard correctional practice, the Port Isabel Police Department and its personnel failed to provide basic intake screening to Mr. Montez;

3) According to the Port Isabel Police Department Policy Manual, the communications dispatcher was required to conduct "periodic prisoner checks every 10 minutes." The policy was violated in Mr. Montez's case because: a) Mr. Montez was found hanging approximately 30 minutes after being last observed through the CCTV monitor by the dispatcher, and b) the CCTV monitor had various blind spots that not only prevented the dispatcher from observing Mr. Montez outside the bench area, but prevented them from observing the decedent hanging from the metal telephone cord in his cell;

4) The Port Isabel Police Department and its personnel failed to provide full CPR on Mr. Montez after he was found hanging. Although Detective Marchan started chest compressions, neither he nor any police department personnel initiated mouth-to-mouth resuscitation on the victim allegedly because protective equipment (e.g., micro shield, pocket mask, Ambu Bag, etc.) was not available. The initiation of CPR was unnecessarily delayed because the police department failed to have such protective equipment in place and available to its personnel;

5) The jail cells within the Port Isabel Police Department contained certain defective and potentially dangerous equipment, namely a CCTV monitor containing blind spots that obstructed full visibility into the cell, and telephone equipment with a metal cord located inside each jail cell that could easily be utilized in a hanging attempt. It was well established within both the law enforcement and corrections fields that CCTV monitors utilized for interior cell surveillance should be positioned in such a way as to provide full and unobstructed visibility of the entire cell interior. Evidence was also presented to show that jail suicides in which victims utilized metal telephone cords to hang themselves were known to have occurred in Texas and throughout the country prior to Mr. Montez's suicide; it was certainly foreseeable that the location of such telephone equipment inside jail cells was dangerous and could potentially result in additional deaths.

6) As a result of the inherent danger of placing telephones with metal cords inside jail cells, jail officials were faced with two options: a) replacing the systems with cordless telephones, or b) prohibiting any type of telephone system inside jail cells. There were several manufacturers and distributors of cordless telephone systems to jail facilities in Texas and throughout the country well before the time of Mr. Montez's death, and the vast majority of jail systems do not place telephones inside single cells.

7) Although not all inmate suicides are preventable, many suicides are averted by jail systems (as indicated by lower jail suicide rates in Texas and around the country generally) that have established suicide prevention programs and trained their staff in the maintenance of the program, as well as in continued awareness and vigilance to inmates that might be at risk for suicide.

The plaintiff's expert concluded by stating that "the suicide of Rolando Montez was both foreseeable and preventable, and the actions and/or inactions by the Port Isabel Police Department, its personnel, and JCW Electronics, Inc. reflected negligence and were the proximate causes of his death."

Defendant JCW Electronics, Inc. presented expert opinions from two consultants. The first, a county jail supervisor from a neighboring state with considerable training and jail inspection experience, chose to ignore discussion of most of the relevant issues in the Montez case. His opinion was essentially limited to the statement: "JCW Electronics, Inc. was never notified or requested by the Port Isabel Police Department to alter, move or relocate the phones to a different location based upon the

objections or obligations to monitor by the Port Isabel Police Department because they presented a safety or security issue inside the cells. Further, JCW Electronics, Inc. was never informed that the cells where the phones were to be installed would be used to hold suicidal or high-risk prisoners or long-term prisoners."

The second expert for JCW Electronics, Inc. was a psychiatrist from Houston, Texas, who prefaced his remarks by opining that "suicide prevention is currently a practical impossibility." In addition, although the medical examiner had ruled that Rolando Montez had committed suicide "with a single ligature mark to neck consistent with hanging," the psychiatric expert for JCW Electronics, Inc. had a different opinion on what caused Mr. Montez's death. In returning to Holding Cell No. 1 in the Port Isabel Police Department on the late afternoon of November 16, 1999, the psychiatrist opined that Rolando Montez did not commit suicide, rather he suffered a "catastrophic cardiac dysrrhythmia (sic)" or heart attack and:

> "most likely was dialing the telephone to call his mother to find out why he hadn't yet been picked up at 5:00pm. He hung the receiver up as he lost consciousness and instantly died. He scraped his knee on the wall as he slumped over. In all medical probability, he was dead before he was actually hung. The telephone was merely a witness to his death, not an accessory.

The City of Port Isabel did not present any expert witness opinions. In fact, the City, as well as Quadrum Telecommunications, Inc., agreed to an out-of-court settlement with the Plaintiff for an undisclosed amount prior to trial.

UPDATE
ON THE INTERNET

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

http://www.igc.org/ncia/suicide.html

Check us out on the Web!
http://www.igc.org/ncia/suicide.html

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

http://www.hhpub.com/journals/crisis/1997
http://www.nicic.org/pubs/jails.htm
http://www.nicic.org/pubs/prisons.htm
http://www.ncjrs.org/html/ojjdp/jjjnl_2000_4/sui.html
http://www.performance-standards.org/resguides.htm
http://www.gainsctr.com

The case proceeded to trial as *Garza v. JCW Electronics, et. al.* (Cause No. 99-11-4765-A). A jury trial was held in Brownsville, Texas during the week of April 8, 2002, in the courtroom of the Honorable District Court Judge Benjamin Euresti, Jr. Following several days of testimony, the jury returned a verdict for the Plaintiff and found that JCW Electronic, Inc. "acted in a fraudulent manner via misrepresentation" and their "breach of implied warranty of fitness for a particular purpose or breach of contract proximately caused the death of Rolando Domingo Montez." On October 2, 2002, Judge Euresti entered a final judgment in the case by awarding $140,000 to Mr. Montez's mother and $376,200 to his son. JCW Electronics, Inc. was also ordered to pay the Plaintiff attorneys' fees.

The Barrera Case

Following the death of her estranged husband, Maria De Lourdes Barrera filed a wrongful death lawsuit in the 107th Judicial District Court of Cameron County, Texas. The defendants were the City of Port Isabel, JCW Electronics, Inc., and Quadrum Telecommunications, Inc., the manufacturer of the telephones used in the city jail. The allegations contained in lawsuit were a replica of those contained in the Montez case. According to *Barrera v. City of Port Isabel, et. al.* (Cause No. 2001-04-1831-C), as a direct and proximate cause of negligence:

> "…the City of Port Isabel failed to supervise the jail section, in particular the jail cell occupied by the decedent….The City of Port Isabel and those described herein are liable for the death of Gavino Barrera as a direct and proximate result of a condition or use of tangible or real property. The decedent was found hung by a phone cord connected to a phone in the decedent's jail cell, which was supposed to be monitored by the employees of the City of Port Isabel….JCW Electronics, Inc. failed to use ordinary care, that is failing to do that which a company of ordinary prudence would have done under same or similar circumstances, in that they failed to modify or make available a phone and accompanying system that was appropriate or in good working order for jail cell use…JCW Electronics, Inc. represented that the jail cell phone and accompanying system was safe for unattended use by inmates….Quadrum Telecommunications, Inc. designed, manufactured, installed and along with JCW Electronic, Inc. marketed a defective product, that being the jail cell phone and accompanying system that was unreasonably dangerous to the user, or Plaintiff in this case, and that product caused physical harm and the eventual death of Gavino Barrera…"

During the discovery phase of the case, experts for both the plaintiff and defendants again lined up to give their opinions. The plaintiff's expert, a national consultant specializing in field of jail suicide prevention, offered the following opinions:

1) It was abundantly clear that several Port Isabel Police Department personnel were aware that Gavino Barrera threatened suicide during the booking process on December 25, 1999, as well as had attempted suicide during a recent prior confinement within the Port Isabel

Police Department. Despite this knowledge of both current and prior risk of suicide, these Port Isabel Police Department personnel did not take any preventative steps to ensure the safety of Mr. Barrera, either by placing him on suicide precautions and/or transporting him to either the local hospital or a mental health professional for assessment. Instead, the decedent's suicidal behavior was dismissed and/or ignored by these personnel;

2) Intake screening is a basic staple of jails and police department lockup facilities throughout the country and is advocated by all national correctional standards. Contrary to this standard correctional practice, the Port Isabel Police Department and its personnel failed to provide basic intake or receiving screening to Mr. Barrera;

3) Despite his obvious risk for suicide, Mr. Barrera was left unobserved by Port Isabel Police Department personnel for more than 60 minutes. This was not only a clear violation of all national correctional standards, but also the written policy of the Port Isabel Police Department. Despite the fact that CCTV monitoring was located in Holding Cell No. 1, Dispatcher McDowell never observed the decedent in the cell, apparently because the CCTV equipment had various blind spots that prevented her from observing Mr. Barrera in the corner of the cell. In addition, the decedent's body could not be seen from the small window in the cell door and was only discovered when Officer Cabrera opened the door and entered the cell. Therefore, even if these personnel were performing their jobs properly, an obstructed view of the interior of Holding Cell No. 1 from the CCTV monitor, as well as the cell door window, caused Mr. Barrera's actions in attempting suicide to go unnoticed and unimpeded;

4) Approximately five weeks prior to Mr. Barrera's suicide, Rolando Montez committed suicide by hanging in the Port Isabel Police Department. That death occurred in the exact same location (Holding Cell No. 1), utilizing the same anchoring device (a metal telephone cord), and under the same circumstances (obstructed view of the cell by both CCTV monitoring and cell door window, and inadequate supervision).

   On December 10, 1999, two weeks before Mr. Barrera's suicide, a meeting was held between City of Port Isabel officials and representatives of JCW Electronics, Inc. The suicide of Rolando Montez was discussed, as well as the future of telephone service to the Port Isabel Police Department. While these individuals offered conflicting statements regarding whether or not they were aware, prior to Mr. Montez's death, that locating telephone equipment with metal cords inside of jail cells was inherently dangerous and could result in suicides by hanging, there could be no dispute that each of these individuals and now Defendants was aware of this danger *following* Mr. Montez's death. Despite this knowledge, these Defendants allowed this inherently dangerous telephone equipment to remain in Holding Cell No. 1 at the time of Mr. Barrera's confinement.

5) Although not all inmate suicides are preventable, many suicides are averted by jail systems (as indicated by lower jail suicide rates in Texas and around the country generally) that have established suicide prevention programs and trained their staff in the maintenance of the program, as well as in continued awareness and vigilance to inmates that might be at risk for suicide.

The plaintiff's expert concluded by stating that "the suicide of Gavino Barrera was both foreseeable and preventable, and the actions and/or inactions by the Port Isabel Police Department, its personnel, and JCW Electronics, Inc. were unconscionable, reflected deliberate indifference, and were the proximate causes of his death."

Both the City of Port Isabel and JCW Electronics, Inc. presented expert opinions from two different consultants, individuals that had not been involved in the Montez case. (Not surprisingly, the previous psychiatric expert for JCW Electronics was not retained.) The expert for the City of Port Isabel, a correctional officer from a neighboring jail, had several opinions about the case that can be summarized as follows:

1) As peace officers, police personnel within the Port Isabel Police Department were not required by any state regulation to receive training in any areas related to jail operations. Officer Martinez, who decided not to place Mr. Barrera on suicide precautions after he threatened self-harm, "made a judgment call according to the facts and circumstances that he perceived at the time."

2) With regard to the obstructive view of the CCTV monitor, "it is standard and a recognized practice in the State of Texas that camera positions are situated to ensure the detainee a reasonable amount of privacy, especially as to the location of the commode."

3) With regard to the dangerous telephone equipment in Mr. Barrera's cell at the time of his death, "City of Port Isabel officials reasonably relied upon the representation and expertise of JCW Electronics to eliminate the risk of any potential suicide incidents relevant to their telephone equipment."

The City of Port Isabel expert concluded by opining that "looking at the circumstances with the perfectly clear vision of hindsight, it is easy to accuse and place blame on the officers that were directly involved in the incident concerning Gavino Barrera. One must recognize, however, that the officers who were directly involved in these events acted within the responsibility and duties of their positions as Peace Officers, given the limits of their knowledge and training….The City of Port Isabel and the Peace Officers and staff involved in this incident acted in a reasonable manner in accordance

with their respective training, job duties, and knowledge of the facts and circumstances."

The expert for JCW Electronics, Inc., who directed a state sheriff's association and a state prison system, and had experience writing jail standards, certainly did not lack for opinions in the case. He had 15 of them, including the following:

1) It is my opinion that in addition to the difficulty of predicting suicidal behavior, there is no constitutionally permissible suicide prevention program that can guarantee success.

2) It is my opinion that it was not unreasonable or inherently dangerous for JCW to install telephones in holding cells in the City's jails.

3) It is my opinion that the telephones were not dangerous nor were they defective in their design.

4) It is my opinion that had a wireless telephone been installed, it would not have prevented Barrera from committing suicide. In fact, the absence of the telephones would have had little, if any, effect on his ability to kill himself.

5) It is my opinion that except in isolated cases, suicides are not preventable in jails. This is especially true when jail officials have not inferred a substantial risk exists that the prisoner is currently experiencing suicide ideation.

6) It is my opinion that reducing the telephone cord to the length of eight inches was a reasonable effort on the part of the parties to eliminate the potential for prisoners to use the cords to commit suicide.

7) It is my opinion that installing phones in cells where prisoners could not be constantly observed is an acceptable practice. My opinion does not extend to cells set aside for known suicide risks.

8) It is my opinion that there is no proximate causal connection between any acts or omissions on the part of JCW Electronics and Barrera's death.

The case of *Barrera v. City of Port Isabel, et al.* was scheduled for trial during the week of October 14, 2002. However, given the verdict and jury award in the Montez case, obvious notice given to the Defendants prior to Mr. Barrera's death (his suicide threat and inherent danger of placing a corded telephone inside a jail cell), as well as opinions espoused by experts for both sides, all of the Defendants agreed to individual out-of-court settlements with the Plaintiff several days before the scheduled trial. Although confidential, the cumulative amount of the settlements was believed to be significant.

Aftermath

And so it goes. The Port Isabel Police Department continues to house inmates in its city jail without adequate policies and procedures, as well as with personnel who lack both jail operations and suicide prevention training. The obstructed view of the cell interiors from the CCTV monitor has not been corrected. But at least the corded telephones are gone. Following the suicides, Chief Ochoa tried to implement intake screening to identify suicidal inmates by including a question on the booking form that stated — "Is this person suicidal?" But, according to the chief, "it wasn't working out. Every prisoner that was brought in, when they were asked that question, would answer 'yes,' so we had the question removed from the form." As for Bradley Woods and JCW Electronics, Inc., they continue to maintain corded telephones inside jail cells in Texas. Some, but not all, of the metal cords have been shortened. Upon request, Mr. Woods will install a cordless telephone system for a customer. But he still furnishes corded telephones and continues to maintain that they are not dangerous when placed inside jail cells. According to Mr. Woods, it is the customer's responsibility to ensure the safety of its inmates. He has not informed his customers about the two inmate suicides in the City of Port Isabel, claiming they were an aberration — "same jail, but still isolated to one city."

For more information regarding the above litigation, contact plaintiffs' counsel Benigno (Trey) Martinez, Esq., Martinez, Barrera and Martinez, L.L.P., 1201 East Van Buren, Brownsville, Texas 78520, (956/546-7159 or e-mail: trey@martinezybarrera.com). ❑

News From Around the Country

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

Illinois

More problems for the Will County Jail in Joliet. We previously spoke about the death of Mark Barnes in the jail facility in September 2001, a suicide that sparked state legislation to mandate the sharing of mental health records between state agencies and county jails within Illinois (see ***Jail Suicide/Mental Health Update***, Volume 11, Number 1, Spring 2002, pp. 9-10.)

Two months following Mr. Barnes' death, police arrested 52-year-old Lawrence Kut on a domestic abuse charge. During the arrest on November 5, 2001, Mr. Kut expressed suicidal ideation to Naperville Police Department officers, who also found a noose in his garage. While temporarily confined in a cell at the police station, Mr. Kut slashed his wrist with his pants zipper. He was treated at a local hospital and then transported to the Will County Jail. Transporting officers from the Naperville Police Department informed the booking officer at the county jail that Mr. Kut had attempted suicide in their custody. The officer relayed the information to the booking sergeant and also noted on a board in her office that Mr. Kut was a suicide risk. Three hours after his

arrival, however, Lawrence Kut was found hanging from a *telephone cord* in his holding cell.

In June 2002, the booking officer was suspended five days without pay, and the booking sergeant was found "guilty of conduct unbecoming and unsatisfactory performance" by the county merit commission. According to the *Suburban Chicago Herald News*, separate lawsuits regarding the two suicides have recently been filed against both officials and staff of the Will County Jail.

Wisconsin

In October 2002, a federal jury awarded $1.825 million to the mother and young son of a mentally ill man who committed suicide at Waupun Correctional Institution in Waupun. Following a trial in front of U.S. District Judge Rudolph T. Randa and more than a day of deliberations, the jury found that two mental health professionals at the prison were liable for the death of 26-year-old Matthew Sanville. The jury ordered Yogesh Pareek, a psychiatrist, and Stephen D. Fleck, a psychologist, to pay $1.65 million in compensatory damages to the decedent's mother, Marti Sanville, and to his son, 8-year-old David. The jury also assessed $175,000 in punitive damages against Dr. Fleck.

"It's been a long fight," Minneapolis attorney Eric Hageman, one of the attorneys who represented Mrs. Sanville, told the Milwaukee *Journal Sentinel*. "They've fought this vigorously throughout the entire case."

Marti Sanville filed the lawsuit shortly after her son's death, alleging that prison officials and mental health professionals had violated his Eighth Amendment rights to be free from "cruel and unusual punishment." Judge Randa originally dismissed the suit on the grounds that correctional officers, prison doctors and top prison officials typically are immune to such legal challenges. In September 2001, however, the 7th Circuit U.S. Court of Appeals partially reversed the dismissal (see ***Jail Suicide/Mental Health Update***, Volume 10, Number 4, Fall 2001, pp. 9-16.), keeping alive Mrs. Sanville's case against the two mental health professionals and a correctional officer, Ivy Scarburdine. The jury found no liability on the part of the officer.

Matthew Sanville was arrested for felony battery after he brutally beat his mother in their Eau Claire home in 1997. His mother told the *Journal Sentinel* in 2000 that she assumed he would be ordered into treatment because of his long history of mental illness. Although the prosecutor recommended probation, Mr. Sanville was sentenced to prison.

According to the 7th Circuit U.S. Court of Appeals, Dr. Pareek advised Mr. Sanville to stop taking his medication because the inmate was having problems with nausea and vomiting. The illness turned out to be appendicitis. After returning from the hospital where he had surgery, Mr. Sanville told the psychiatrist he did not want to go back on his medication. Dr. Pareek honored the request, and Mr. Sanville's behavior became "increasingly bizarre," according to court documents. He scrawled threats on his sheets and assaulted another inmate. As a result of the assault, Mr. Sanville was placed in isolation. After he refused to return his meal trays and bags from lunches, he was given

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

only "nutri-loaf," a meal ground into a loaf that can be eaten without utensils. He refused to eat it and lost 45 pounds — about one-third of his body weight, court records showed. Mr. Sanville also had written a will and threatened suicide, but no action was taken.

Dr. Fleck first met with Mr. Sanville after the young man's mother called the prison to express concern about her son's mental stability. According to the 7th Circuit U.S. Court of Appeals opinion, the psychologist was "satisfied with Matt's insistence that he had no plans to harm himself. . . . Dr. Fleck's report did not make any reference to Matt's weight." Three days later, Dr. Fleck saw Mr. Sanville again, and concluded that he would follow up in four to six weeks. The psychologist received another mental health request from the inmate the next day and scheduled an appointment for July 30. Matthew Sanville killed himself on July 29, 1998.

New York

On any given night in the Albany County jail, roughly 45 to 60 of the approximately 875 inmates are isolated and confined to a segregated wing because they are mentally ill and might be preyed upon by other prisoners. What to do with these troubled offenders, whose numbers are climbing, is a growing problem. "I don't know what the answer is, but jail is not the place for many of these people," Sheriff James Campbell told the *Albany Times Union* in October 2002. "We're not a treatment center. There has to be a better alternative."

There may be one arriving in the near future. The Albany County Jail Diversion Program will begin shortly with a $300,000 grant from the Center for Mental Health Services, a federal agency within the Substance Abuse and Mental Health Services Administration. An estimated 15 to 25 inmates are projected to be part of the program in its first year. The pilot program will attempt to divert selected mentally ill individuals — typically convicted of misdemeanor, nonviolent crimes — away from the criminal justice system and into community mental health treatment programs.

"This is an important first step," Joseph Glazer, president of Mental Health Association in New York State Inc.," told the *Albany Times Union*. "Most mentally ill people who go to state prison come through the county jail system three or four times for lower crimes," said Mr. Glazer, whose agency applied for the grant and is administering the program. "Research shows that early intervention is the most critical factor in treating mental illness. If we can divert mentally ill people out of jail, we believe we can keep them out of the state prison system."

The pilot program will be a collaborative effort involving personnel from police, jail, district attorney's office, courts, defense bar, and the local mental health agency. A forensic case manager will work in Albany City Court. Participation in the program will be voluntary. The defendant must be identified as mentally ill by police, a judge or family members. The defendant then must apply to the program and be assessed by a mental health professional. After a consultation among the various parties, a mandatory treatment plan will be developed. The defendant must stick with the program, which typically involves a psychotropic medication regimen, individual and group therapy sessions, and meetings to assist recovery from substance abuse if needed. Compliance will be closely monitored and if the defendant does not follow through with treatment, or fails to take medication, they could be incarcerated.

A built-in incentive for the defendant who successfully completes the program and commits no further crimes for one year is that the conviction will be removed from their criminal record. Mr. Glazer said that element of the program is aimed at future employability. "A person who had substance abuse issues, mental health problems and a criminal record labels them as unemployable," he said. "If they can't find a job, they're back on the streets, committing crimes, landing back in jail, eventually state prison, and the cycle starts over again."

Connecticut

The family of the man who hanged himself in the Plainville Police Department lockup in December 2002 recently notified the town of its intention of filing a lawsuit, claiming negligence by officers led to his suicide. John Rasmus died December 15, 2002 after being arrested earlier that day and accused of fighting with his wife.

According to the initial investigation into the death, one of the arresting officers was sufficiently concerned about Mr. Rasmus's emotional state that he filed a report shortly after the booking process indicating that the detainee was a suicide risk. That officer told the dispatcher of his concerns so she would closely monitor Mr. Rasmus during the night. The officer also told the shift commander that Mr. Rasmus had talked about killing police officers and then himself. The arresting officer also filed a supplemental report indicating Mr. Rasmus was emotionally disturbed and had talked about harming himself. Police officials have said this second report was supposed to be signed by a supervisor, but had not been. The officer placed his second report in an area of the dispatch center where staff working that night could easily see it.

While in the holding cell, Mr. Rasmus tied one sleeve of a shirt around his neck and the other around one of the cell bars. He then sat down on the bunk with enough downward pressure to asphyxiate himself. Police officials have acknowledged that cameras used to monitor the cells from the dispatch area did not provide a full view inside the cells, and that staff could not get a clear view of Mr. Rasmus as he sat on the bunk.

Arizona

In late January 2003, county officials agreed to pay a Mesa family $175,000 after a family member committed suicide in Maricopa County Jail in Phoenix. The settlement ended a prolonged five-year legal battle. Attorneys for the family of 33-year-old David Hyslop claimed that he was clearly depressed and kept crying out for help, but that jail mental health staff ignored, and deputies punished, the inmate.

According to the lawsuit, David Hyslop was arrested on suspicion of driving under the influence of alcohol and transported to the

Maricopa County Jail in April 1997. He suffered from a depressive disorder and repeatedly expressed suicidal ideation during confinement. Mr. Hyslop also tested high on a suicide risk assessment and refused to sign a "no suicide" contract. He was repeatedly sent to the jail's psychiatric unit, given medication and limited treatment, and moved back into the general population. At one point, agitated because he was not receiving proper care, Mr. Hyslop punched a cell wall. As a result, he was placed in isolation. Shortly thereafter on July 4, 1997, David Hyslop tied one end of a bed sheet around his neck and attached the other end to a window bar and hung himself.

"It was really a tragic situation," a spokesman for the Maricopa County Sheriff's Office told *The Arizona Republic* on January 29, 2003. "But it was something pretty much of his own making….If someone truly, truly wants to commit suicide, they're going to." David Don, representing the family disagreed, stating that "David Hyslop and most people in the Maricopa County jails are awaiting trial. They have a right to adequate health care. When they get into the jails, the sheriff should hold them there and keep them alive. They shouldn't get a death sentence while awaiting trial."

Then two weeks later in early February 2003, the Maricopa County Board of Supervisors again agreed to settle a lawsuit arising from another suicide at the county jail. The board agreed to pay $200,000 to the family of Thomas Ball in settlement of the lawsuit. "We weren't consulted on the decision, and I think it was a business decision by Risk Management," a spokesman for the Maricopa County Sheriff's Office told *The Arizona Republic* on February 5, 2003. "We think this was an entirely defensible lawsuit. No question about it."

Thomas Ball, 40-years-old, was arrested in August 1998 on suspicion of driving under the influence of alcohol and driving with a suspended license. He was booked into the Maricopa County Jail. Two days later, he tried to strangle himself with a shoelace and was admitted into the jail's psychiatric unit. He was eventually released from custody but rearrested six weeks later on October 11 for attempting to break into his mother's home. Mr. Ball was once again brought to the Maricopa County Jail. Although given medication for his withdrawal from heroin, medical and correctional personnel failed to review his prior records which documented Mr. Ball's recent suicidal behavior in their jail system. On October 13, 1998, Thomas Ball committed suicide by hanging himself with a bed sheet.

Montana

The American Civil Liberties Union (ACLU) of Montana has threatened to sue county officials unless a plan to fix "unconstitutional" conditions in the Gallatin County Jail in Bozeman is in place within 45 days. During an October 2002 tour of the jail, the ACLU found the jail to be overcrowded, filthy and short-staffed. "The county has an obligation to treat (inmates) fairly," Beth Brenneman, the group's legal director, told the *Bozeman Daily Chronicle* on January 28, 2003. "Most of them haven't been convicted of a crime."

During the tour, ACLU staff discovered broken toilets, clogged air vents and filthy showers. According to the group, two inmates were frequently crammed into cells designed to hold one, the jail was grossly understaffed, and lacked adequate services for the mentally ill. "The total absence of any crisis mental health support or adequate security staff makes it nearly impossible for your facility to keep those in crisis safe," Ms. Brenneman wrote to the Gallatin County Commission. "This is evident from the circumstances of the deaths in your facility." The ACLU had toured the Gallatin County Jail hours after 19-year-old Jason Finn hanged himself. It was the third suicide in the 37-bed facility jail within 18 months.

County Sheriff Jim Cashell said the ACLU's comments accurately described jail conditions. "I have to agree with them," he said. "This is what we've been saying for 11 years now." Regarding the October 2002 death of Mr. Finn, Sheriff Cashell stated that "this shouldn't come as a surprise. We do not have a mental health system in place to deal with mental health problems." But County Commissioner Jennifer Smith Mitchell said the ACLU's conclusions were disappointing because the county had recently taken remedial measures to improve the facility. "Their letter is full of a whole bunch of things that we've already taken care of," Ms. Mitchell said. "I don't know where they're getting their information or who's bending their ear." The county commissioner suspected somebody inside the jail might be encouraging the ACLU to file the lawsuit. "There are people out there who are very impatient and they want a new jail regardless of what it costs the taxpayers," she told the *Bozeman Daily Chronicle*. "I think that there is somebody inside who is pushing buttons."

ACLU Director Brenneman denied those allegations. "The ACLU makes its own decisions as to whether to send these kind of letters and whether to litigate," she said. "This kind of litigation does take a lot of time and a lot of resources, it's not something to take lightly." And unless the county has done a lot of work in the past three months, the county commissioner is wrong about conditions at the county jail, Ms. Brenneman stated. Commissioner Mitchell responded by saying that, if the jail is filthy, the sheriff is to blame. Sheriff Cashell told the *Bozeman Daily Chronicle* that his staff try to keep the jail clean and well maintained, but acknowledged there are problems. "When you cram 60, 70 and sometimes 80 people in a facility that's designed to hold less than 40, sometimes you're going to fall down," he said. "They work every day to keep the place as clean as we can." The sheriff also said no one from his office has asked the ACLU to file a lawsuit. He and the county attorney plan to meet with the commissioners to decide how to respond to the ACLU's threatened litigation. There was no word on whether the discussion will include the issue of suicide prevention practices within the Gallatin County Jail.

California

County officials in Los Angeles have agreed to a series of sweeping reforms aimed at better identifying and treating thousands of mentally ill inmates in the nation's largest jail system, heading off a possible civil rights lawsuit by the U.S Justice Department. The agreement, which was finalized in December 2002, followed years of alleged abuses in Los Angeles County jails, including excessive force and the improper use of restraints that led to the deaths of at least two mentally ill inmates.

Under terms of the *Memorandum of Agreement Between the United States and Los Angeles County, California Regarding Mental Health Services at the Los Angeles County Jail*, Los

Angeles County agreed to new standards governing almost every stage of care for the estimated 2,500 mentally ill inmates currently being held, from intake screening and diagnosis to drug treatment, suicide prevention and medical record-keeping.

Los Angeles County Sheriff Lee Baca, whose department runs the jail system, told the *Associated Press* that negotiations with the Justice Department had already produced important changes. "The system we've developed is far more effective in providing proper services and making sure that people, when they get out of jail, don't come back because of their mental health problems," he said.

Since the investigation began in 1996, the Los Angles County Sheriff's Department has moved mentally ill inmates into modern facilities at the downtown Twin Towers jail and launched a computerized system to track inmate medical records. The county Department of Mental Health, which oversees inmate psychiatric care, has doubled its staff in the jail system.

"The county has made substantial improvements in its treatment of inmates with mental illness. There's still more work to be done," Steven H. Rosenbaum, special litigation section chief of the Justice Department's Civil Rights Division told the *Associated Press*.

After a scathing report by the Justice Department concluded the county was violating the inmates' constitutional rights, officials began devoting more attention and money to the situation. The county now spends more than $20 million a year on jail mental health services. "This has been a long, hard haul," said Merrick Bobb, special counsel to the Board of Supervisors. "There was a focused effort by the Sheriff's Department to overcome those problems and to allocate the necessary resources and staff."

The *Memorandum of Agreement* now requires the county to conduct mental health screening of all inmates entering the jail system. Trained mental health personnel will develop comprehensive treatment plans for mentally ill inmates, and no inmate with mental illness will be locked down for more than 19 hours per day. Psychotropic medication will be properly prescribed and documented, and suicidal inmates placed in a safe setting and promptly evaluated.

The suicide prevention requirements of the agreement are as follows:

- The County shall ensure that inmates observed to be potentially suicidal receive appropriate crisis intervention, (including placement in a safe setting and evaluations in a timely manner), by a qualified mental health professional to determine whether and what level of suicide observation is required;
- An inmate under suicide observation shall be evaluated by a qualified mental health professional prior to being removed from mental health observation;
- Suicide intervention procedures shall permit correctional staff to administer appropriate first-aid measures immediately. All correctional officers shall be trained in first aid and cardiopulmonary resuscitation ("CPR") cut-down techniques and emergency notification procedures in the event of hanging. Officers shall have cut-down tools available;
- Suicide watch procedures shall provide for fifteen-minute suicide watch and may be modified to provide for five-minute suicide watch with the concurrence of custody administration and staff. Suicide watch must be documented;
- Suicide observation cells and dormitories shall be maintained in a manner that is safe and will not exacerbate a suicidal inmate's mental condition. Inmates under suicide observation should be within sight of staff; and
- All staff shall receive annual suicide prevention training.

The full *Memorandum of Agreement* is available for viewing at the following U.S. Justice Department website: http://www.usdoj.gov/crt/split/documents/lacountyjail_mh.htm

Pennsylvania

A homeless man who committed suicide in a police department holding cell in West Chester hours after he was charged with rape has since been cleared of the crime through DNA evidence. Police Sergeant Thomas Yarnall told the *Associated Press* in January 2003 that forensic evidence collected after the alleged rape did not genetically match that of Wade Evan Deemer. Mr. Deemer hanged himself with his shirt in a holding cell at the West Chester Police Department in August 2002. "It's not his DNA. It appears that he did not do it," Sergeant Yarnall said.

Wade Deemer, 41-years-old, was arrested on August 24, 2002 after he was identified by an 18-year-old woman as the individual who forced her into the woods near a convenience store and raped her. According to his stepmother, Mr. Deemer had been diagnosed with bipolar disorder the previous year and did not have his medication with him at the time of arrest. "He was depressed and this trauma of the arrest was just too much for him to deal with," Connie Deemer said.

Alabama

An inmate found dead in his cell recently was the second to commit suicide in the Pickens County Jail in three years. Anthony Jerome Wilder, 23-years-old, had been at the 54-bed facility in Carrollton since May 2002 on a charged of murder. On January 3, 2003, Mr. Wilder was found hanging in his cell by other inmates as they walked down the corridor to breakfast at approximately 6:45am. He had tied a towel around his neck and attached it to the cell bar.

According to Sheriff David Abston, his staff last had contact with Mr. Wilder more than four hours earlier at 2:00am. "The last time he talked to a jailer, he asked what time it was. She didn't notice anything

out of the ordinary about his condition that would have tipped us off that he was suicidal," he told the *Tuscaloosa News*.

In May 2002, Mr. Wilder had been placed on suicide watch after informing jail staff that he was suicidal. He was taken off suicide precautions three months later on July 11 after signing a "no-suicide" contract promising the jail staff he would not hurt himself.

"All of us are shook up. We'll go over policies and procedures to see what we can do to prevent this from happening again," Sheriff Abston said. "It is very difficult to prevent people who are suicidal from killing themselves if they're determined to do it."

The policy for requiring "no-suicide" contracts was implemented after 24-year-old Kendrick Latham committed suicide in the Pickens County Jail in September 2000. A lawsuit against two jail personnel is still pending in federal court.

Oregon

Similar to state laws throughout the country, Oregon law requires that if a court finds a criminal defendant is suffering from mental illness and does not understand the nature of the proceedings against them and/or is unable to participate in the defense of the case, the individual will be transferred to the Oregon State Hospital (OSH) in Salem in a timely fashion for evaluation and treatment. In March 2002, the Oregon Advocacy Center and the Metropolitan Public Defenders Service in Multnomah County sued the Oregon State Hospital alleging that dozens of individuals with mental illness languish in county jails across the state for more than a month while they await bed space at the state facility. In defense of the OSH, state officials contended that taking every inmate, regardless of whether there is a available bed, would risk the health and safety of patients and hospital staff, as well as disrupt the therapeutic environment of patients already at the hospital. They also maintained the state lacks the money to provide enough beds, and that inmates receive adequate care while they are housed in county jails.

In May 2002, United States District Court Judge Owen M. Panner sided with the plaintiffs, determining that some mentally ill pre-trial defendants were being held in county jails from between one and four months prior to transfer to the OSH, and found that the state was not doing enough to resolve the problem. As such, the court ruled that the state's behavior "demonstrates a deliberate indifference to these persons' health, safety and constitutional rights" and that its policies "are a substantial departure from professionally accepted minimum standards of treatment of incompetent individuals for whom defendants are responsible." Judge Panner issued an order requiring the state to admit "incapacitated criminal defendants" into the OSH within seven days of a judicial finding of their incapacity to proceed to trial.

The state appealed the ruling to the United States Court of Appeals for the Ninth Circuit Court of Appeals. In September 2002, the appeals court heard arguments from both sides. Richard D. Wasserman, an assistant attorney general, argued that the OSH was under no legal obligation to accept inmates within a set time period, and that jails could contract for psychiatric services from community providers. "Until there is an open bed at the state hospital, the counties are responsible to provide whatever mental health care is appropriate," he stated. "The place where they are housed doesn't determine the level of care they are allowed. The Constitution determines that." Kathleen L. Wilde, attorney for the Oregon Advocacy Center, argued that "jails do not have the capacity to provide restorative mental health treatment. A jail is not a hospital, and that's what the court found. As a constitutional manner, it's got to be provided, and it's only available at the state hospital." The case was taken under advisement.

On March 6, 2003, a three-judge panel for United States Court of Appeals for the Ninth Circuit agreed with the plaintiffs and issued a unanimous ruling that upheld the lower court order that "incapacitated criminal defendants" were required to be transferred from a county jail to the OSH within seven days. Writing for the appeals court, Judge Raymond C. Fisher stated in *Oregon Advocacy Center v. Mink* (No. 02-35530) that:

> …In assessing the merits of OSH's due process arguments, we are mindful that by statute OSH is solely responsible for the timely treatment of incapacitated criminal defendants so that they may become competent to stand trial. We are also mindful of the undisputed harms that incapacitated criminal defendants suffer when they spend weeks or months in jail waiting transfer to OSH. These harms include the following: Although jails can sometimes provide treatment to stabilize a patient, they cannot restore a patient to competency. Thus, incarceration in a county jail delays an incapacitated criminal defendant's possible return to competency. The disciplinary system that jails use to control inmates is ineffective for, and possibly harmful to, incapacitated criminal defendants. Because of the unpredictable or disruptive behavior, they are often locked in their cells for 22 to 23 hours a day, which further exacerbates their mental illness. Incapacitated criminal defendants have a high risk of suicide, and the longer they are deprived of treatment, the greater the likelihood they will decompensate and suffer unduly. These and other undisputed harms, together with OSH's statutory mandate to provide timely restorative treatment, support our conclusion below that OSH's delay in admitting incapacitated criminal defendants violates their substantive due process rights….We uphold the district court's injunction requiring OSH to admit mentally incapacitated criminal defendants within seven days of a judicial finding of incapacitation.

Reacting to the ruling, Kevin Neely, a spokesman for Oregon Attorney General's Office, told *The Oregonian* that "Clearly this poses some very big problems for the state hospital in terms of capacity and the very short timeline that it requires the hospital to accept these individuals. It's a Catch-22 for the state. Everybody knows we have a tremendous budget problem, and this is yet another blow." Responded Attorney Wilde from the Oregon Advocacy Center, "The court specifically said that the fact that there is no money doesn't excuse a breach of this order." Her agency will monitor the waiting list to ensure that the hospital remains in compliance with the court order.

Most of the inmates affected by the ruling are confined in the Multnomah County Jail system in Portland. Sheriff Bernie Guisto believes the ruling bolsters the position of sheriffs around the state who are cutting budgets while trying to meet the demand for jail space, as well as the needs of mentally ill inmates. "This kind of ruling tells the state that they have a constitutional responsibility to take these inmates," he told *The Oregonian*. "It's about getting the mentally ill on the right track."

Ohio

In November 2002, the coroner's office was still conducting tests to determine the cause of death for 34-year-old Elizabeth Prusaczyk in the Jefferson County Jail in Steubenville. Ms. Prusaczyk had been arrested on November 7 and charged with public intoxication, disorderly conduct, and having an open container of alcohol. Upon entry into the facility, Ms. Prusaczyk was said to very aggressive with jail staff. "She tried to bite one of the corrections officers, and she was very combative while she was here," Sheriff Fred Abdalla told *The Intelligencer* of Wheeling, West Virginia. "We had to keep her under 24-hour watch, and we held her in the detox cell also." A week later, she was found dead in her cell.

Ms. Prusaczyk was the second inmate to die in the 33-bed facility in less than three weeks. At approximately 1:25pm on October 26, 2002, a jail officer found 41-year-old Steven Moorehead dead in his cell two days prior to his scheduled murder trial. Mr. Moorehead had been well known to local law enforcement authorities and claimed to have killed up to six people in Ohio and Pennsylvania. Jail officials initially thought that Mr. Moorehead died of natural causes. According to Sheriff Fred Abdalla, "It looked like it was a heart attack. He was alive at 7:30 in the morning, I know that." However, the medical examiner later determined that Mr. Moorehead died from a fatal overdose of his psychotropic medication.

Despite the two recent deaths, the sheriff was not concerned about safety issues in the jail "This jail is safe, and no one should be concerned about the safety of these prisoners," he said. "Moorehead is dead because he wanted to die, and he stored medicine in his body cavity so he could die. (Prusaczyk) admitted she was an alcoholic. ... Neither one of these deaths had anything to do with the safety of the jail." Sheriff Abdalla also did not believe it necessary to investigate either of the deaths nor jail operations at the Jefferson County Jail. "There is nothing to investigate here…There was no way to prevent this."

Georgia

An inmate at the Cobb County Adult Detention Center in Marietta strangled himself with a bed sheet in September 2002, marking the second inmate suicide in as many months. But, Sheriff Bill Huston told the *Marietta Daily Journal* that jail suicides are a relatively common nationwide problem. "I've been in this business for 40 years, and inmate suicides have been a problem in every jail all across America," said the sheriff. "If a person is intent on taking their own life, then they will do it, and it is very difficult to prevent."

According to a jail report, 22-year-old Johnny Kelton Robinson was found sitting on the cell floor with one end of the bed sheet tied around his neck and the other tied to the top corner of his bunk. The inmate was being held on three felony charges including possession of cocaine and aggravated assault.

Sheriff Huston said an administrative review will be conducted to ensure all personnel followed procedure, but in order to guarantee "that an inmate would never commit suicide, I would have to have one deputy watching each inmate 24 hours a day, seven days a week, and that we just cannot do," he said. "We don't have the staff or the resources."

In September 2002, 36-year-old Elizabeth Ann Clark strangled herself with a *telephone cord* while confined in a holding cell at the jail.

Sheriff Hutson conceded that the ongoing problem of inmate suicides needs to be addressed. "Two suicides in two months is just not normal," he said. "The only thing I can think of doing is increasing the mental health care evaluations earlier on. We are being forced to deal with these mental health problems in the criminal justice system when it should be done within institutions that specifically treat the mentally ill."

Connecticut

A successful social services program in Norwich that diverted the mentally ill from jails and into treatment programs will lose most of its potency as a result of the state's proposed budget cuts. The reduction calls for 67 psychiatric social workers across the state being laid off, severely hampering the Jail Diversion Program. The program, created nine years ago following closing of Norwich State Hospital, was designed to allow for a social worker to evaluate a mentally ill defendant and find a community program commensurate with their treatment needs.

Paul Cummings, a psychiatric social worker with the state Department of Mental Health and Addiction Services (DMHAS) for 23 years, is among those laid off. He helped create the Jail Diversion Program nine years ago for the local court system. "The first year we were able to refer 100 clients to treatment. Last year we referred 440," Mr. Cummings told the *Norwich Bulletin* in February 2003.

DMHAS had assigned four social workers involved in the program; the layoffs will cut that number to two staff. "Now social workers will only be available to help the court once in a great while, when they should be in the courts on a regular basis," Mr. Cummings said. He spent approximately four hours per day with the Jail Diversion Program. Once the layoffs go into effect, overburdened social workers will only be in the courthouses one or two days a week.

Dr. Wayne Dailey, spokesman for DMHAS, said until a compromise is worked out in the state legislature, there would be a reduction in services. Social workers will go to court on certain days of the week and will be available on an emergency basis, he said, adding that "we hope we can cover those requests." But according to Paul Cummings, "The program will exist on paper only and not in reality."

Judge Kevin McMahon, presiding judge of New London Superior Court, is frustrated that the program will suffer. "I have been in the criminal justice system for 27 years and it was the best program I have ever seen deal with the mentally ill," he said. The court system was never properly equipped to deal with the mentally ill, and "this program really addressed the problem."

Iowa

On December 17, 1997, 25-year-old David Sylvester Price tied one end of a bed sheet around his neck and the other end to a window bar in the 272-bed Black Hawk County Jail. He was found by correctional staff shortly thereafter, transported to the local hospital, and pronounced dead. The suicide was immediately reported to the state Department of Corrections and the chief jail inspector toured the facility in Waterloo the following day. Following a review of policies and procedures, as well as reports of the incident, the inspector concluded that there appeared to be no wrongdoing regarding Mr. Price's death. "My main interest was to make sure the jail did what they were supposed to do…I'm completely satisfied," the inspector told the *Waterloo-Cedar Falls Courier* at the time.

In May 1998, however, the Special Litigation Section of the U.S. Justice Department's Civil Rights Division initiated an investigation of mental health treatment and services at the Black Hawk County Jail. The investigation was prompted by allegations from the Black Hawk County Alliance for the Mentally Ill which had received complaints of inadequate treatment from inmates and their families. The subsequent investigation evolved into other areas of conditions of confinement. In a letter which summarized its findings in January 1999, the Justice Department concluded that the jail violated the inmates' constitutional rights with respect to medical and mental health care, suicide prevention, inmate supervision and protection from harm, and improper use of the restraint chair. Concerns regarding excessive use of force were also raised.

Both the suicide of David Price and inadequate suicide prevention practices were highlighted in the Justice Department's investigative report which stated, in part, that:

> …Between July 1997 and July 1998, the Jail's nursing staff routinely evaluated and dismissed inmates' sick call requests for mental health treatment with little or no input from qualified mental health professionals, including the Jail's contracted mental health provider. There was virtually no mental health counseling or crisis intervention program available at the Jail. As a result, inmates with serious mental illnesses did not receive adequate assessment of or treatment for their conditions.
>
> A tragic example of this deficiency occurred when an inmate, who claimed to have received mental health treatment on the outside, requested to see mental health personnel. According to nursing notes, a nurse told the inmate that "we do not routinely have (mental health personnel) come out," and advised him "to read, exercise and talk with others." Nursing notes indicate that the nurse called outside providers to determine whether the inmate was on medication (he was not), but no further follow-up or evaluation was ordered. Two days later, this inmate hanged himself from a horizontal window bar in his cell. …The systemic deficiencies in the Jail's provision of mental health care, including inadequate screening, lack of counseling and crisis intervention, and lack of on-site mental health personnel, have also led to inadequate suicide prevention. There is a lack of mental health input into both the identification and treatment of suicidal inmates.

For example, one inmate who attempted suicide by hanging was restrained in the restraint chair for an hour and placed on a 30- minute watch for about 12 hours. The only nursing note regarding this suicide attempt indicated that the inmate was "just worked up about wife and everything was closing in." The nursing staff apparently concluded that there was no need for a mental health evaluation or suicide risk assessment by mental health personnel. No mental health counseling or crisis intervention services were sought or provided. Other incident reports involving attempted suicides similarly revealed an absence of mental health follow-up.

Following the initial investigation, attorneys with Justice Department and legal counsel for the Black Hawk County Jail spent considerable time negotiating a settlement. During this period, the family of David Price filed a lawsuit against the county alleging that his suicide was the result of grossly inadequate mental health services. Ultimately, Black Hawk County agreed to correct all of the deficiencies identified by the Justice Department investigation, as well as bolster its mental health services. Specifically, the county agreed to the following remedial changes regarding mental health services and suicide prevention:

- ***Staffing:*** Develop a quality assurance plan to ensure that the level of staffing provided under the County's recent contract for mental health services is sufficient to identify and treat in an individualized manner those inmates suffering from serious mental disorders.

- ***Intake:*** Establish a system of collecting mental health-related information that will ensure confidentiality. The Jail's screening process should not rely on an inmate self-reporting his or her mental illness in a group setting.

- ***Evaluation:*** Provide an adequate and timely mental health evaluation, by a qualified and appropriately trained mental health professional, of inmates who screen positive for possible mental illness at intake (including where relatives or other close associates provide information relating to the inmate's possible mental illness), and of inmates who exhibit symptoms of mental illness (including suicidal ideation or behavior) at any time during their incarceration.

- ***Sick Call:*** Ensure that all inmates requesting mental health care are seen and evaluated by a qualified and appropriately trained mental health professional. Ensure review of mental health-related sick calls by the Jail's psychiatrist.

- ***Treatment:*** Ensure that an individual, written, mental health treatment plan is prepared in a timely manner by a qualified and appropriately trained mental health

professional for every seriously mentally ill inmate. Changes to and compliance with the treatment plan should be thoroughly and accurately documented in the inmate's medical/mental health record.

- ***Medication Management:*** Avoid unreasonable interruptions in inmates' medications upon admission to the Jail. Ensure that the Jail's psychiatrist is involved in the monitoring and follow-up of inmates on medications for psychiatric conditions, including cases where there is inmate noncompliance with medications. Ensure that decisions whether to prescribe or terminate medications, including controlled substances, are based on clinical assessments by the Jail's psychiatrist, and that medically-approved detoxification procedures are utilized.

- ***Counseling/Crisis Intervention:*** Provide adequate counseling and crisis intervention services for all mentally ill inmates who need such care, including, but not limited, to inmates who are observed to be potentially suicidal.

- ***Emergency and Acute Care:*** Ensure that the Jail's psychiatrist is on-call and consulted in the event of mental health emergencies. Consistent with security requirements, inmates with acute psychiatric conditions should be promptly transferred from the Jail to a treatment facility.

- ***Barriers to Access:*** Ensure that inmates are informed in the Jail's orientation video and in the Inmate Handbook of the availability of mental health services and of the Jail's exception to the fee-for-service policy for mental health encounters.

- ***Use of Restraint and Isolation:*** Develop a comprehensive policy on the use of restraint and isolation on inmates with serious mental illnesses. Ensure that mental health personnel are involved in decisions to restrain or isolate mentally ill inmates, and in the monitoring of such inmates while restrained or isolated. Develop policies and procedures to ensure that inmates with acute psychiatric conditions, who cannot function long term in the general Jail population, are transferred or committed to appropriate treatment facilities as expeditiously as possible.

- ***Physical Features Creating Unacceptable Opportunities for Suicide:*** Modify, on a priority basis, all Special Housing Unit areas and the inmate intake area of the Jail to eliminate physical hazards, thereby lessening the risk of suicidal behavior. These modifications include: covering air grille areas in the cells with small diameter mesh or some other material to prevent inmates from attempting to hang from this fixture; replacing window caulking in a manner that will prevent its removal; shielding handicap grab bars to prevent inmates from tying material around the bar; removing curtains and rods from shower stalls; removing the solid wooden door to the washroom in the "honor" intake and booking area (a privacy panel may be installed); and removing cleaning items daily from Special Housing Unit cells to prevent the fashioning of weapons. Additionally, all inmate housing units should have properly secured readily available cutting tools (designed to interrupt suicide attempts).

Although not part of the settlement agreement, the county also voluntarily sought accreditation from the National Commission on Correctional Health Care.

In early March 2003, following a series of three inspections by consultants with the Justice Department, the Black Hawk County Jail was found to be in compliance with the settlement agreement and the five-year federal investigation was closed. "The only reason this concluded in the fashion it did was because of the professionalism and pride of the people who work here," Captain Mark Johnson of the Black Hawk County Sheriff's Office told the *Waterloo-Cedar Falls Courier* on March 19. "It has been a team effort all the way."

The only outstanding issue that remained was the wrongful death lawsuit filed by David Price's family. In late March, following a mandatory settlement conference, the family accepted a $300,000 offer from the county's insurance carrier.

Virginia

The state police recently launched an investigation into two inmate suicides at the Loudoun County Adult Detention Center in Leesburg. Both suicides occurred less than two weeks apart in March 2003. "It is the position of this office that both of these incidents warrant an independent criminal investigation in avoiding any conflict of interest or the appearance of such a conflict within the Loudoun County Sheriff's Office or this office," Commonwealth Attorney Bob Anderson told the *Loudoun Times-Mirror* on March 26.

On March 11, jail deputies found Thomas Tacey hanging by a bed sheet that was tied to his cell bars. Nine days later on March 20, Michael Rohrer was also found hanging by a bed sheet that was tied to his cell bars in another housing unit at the 110-bed facility. An internal review of both deaths by the Loudoun County Sheriff's Office determined that proper procedures were followed in each case.

The family of Michael Rohrer did not await results from the state police investigation before criticizing the Sheriff's Office for not placing their son under suicide precautions due to his recent history of suicide attempts, at least three of which occurred within the last year while under the care of the Loudoun County Mental Health Department. Richard Rohrer, the victim's father, told the *Loudoun Times-Mirror* that the family found a witness who told them Michael had threatened suicide several days before his death during an incident in which deputies had taken him to the hospital after he suffered a seizure.

Regina Rohrer said Michael had called her on March 18, after the hospital incident and just two days before his death, to say that

jail deputies had sprayed him with mace and placed him in a restraint chair after he became unruly at the hospital. She claimed her 21-year-old son had been "very distressed" and "very despondent" following Thomas Tacey's suicide the previous week, telling her that the inmate had been "utterly defenseless and utterly picked on by the other criminals" in his cell block. Mrs. Rohrer said mental health personnel had doubled her son's medication following Mr. Tacey's suicide, and that he had seemed incoherent during their conversation. "He was crying out for help for a long time," Regina Rohrer told the *Loudoun Times-Mirror*. "I don't get it, that's my outrage," she said. "How on earth could this happen?"

Loudoun County Sheriff Steve Simpson declined to comment about the family's accusations while the state police investigation was ongoing. He did say, however, that the deaths were "unfortunate," his deputies had acted properly, and that the investigation will "set people at ease" about what happened.

Florida

News of an inmate's recent apparent suicide in the Pasco County Detention Center in Land O' Lakes has sparked outrage among mental health advocates in the county. The incident is being cited by some in the legal and mental health communities as the consequence of forcing jails to warehouse the mentally ill. "Jail is no place for someone with a mental illness," Fay White of the National Alliance for the Mentally Ill's West Pasco Chapter told the *Tampa Tribune*. "There has to be more done, or this is going to keep happening."

Norman Ayoub, 33-years-old, had bounced between hospital psychiatric wards and the county jails since 1998, struggling with mental illness and substance abuse. He had also attempted suicide several times, and had previously been placed on suicide watch in the Pasco County Detention Center. Upon his most recent entry in the jail on March 31, 2003, deputies were told that Mr. Ayoub was diagnosed with schizophrenia, depression and an anxiety disorder. "When his illness was under control with medication, he was a perfectly wonderful person," said Sara Sanchez, an assistant public defender who represented Mr. Ayoub for several years. "I think he had a hard time finding his way in the world…We always had trouble finding him a place to live, but I never saw him as someone who would give up."

Mr. Ayoub's most recent arrest involved a charge of violating his probation. He reportedly told a probation officer on March 31 he had taken 11 Percocet pills a few days earlier. The information was passed on to jail staff and they had been "keeping an eye" on Mr. Ayoub because he had also threatened suicide to a deputy. Kevin Doll, spokesman for the Pasco County Sheriff's Office, told the *Tampa Tribune* that Mr. Ayoub was transferred to the jail's medical wing and checked on a regular basis. "He wasn't placed on suicide watch," Mr. Doll stated. "That isn't done unless someone attempts suicide or a doctor determines they are at risk for it."

Norman Ayoub was awaiting a court date when a deputy found him on the floor of his cell floor with a bed sheet wrapped around his neck during the late evening of April 9. The deputy called for assistance, a second deputy arrived, and they both began cardiopulmonary resuscitation. Mr. Ayoub was later pronounced dead by emergency medical personnel.

The Pasco County Sheriff's Office is conducting separate criminal and internal investigations into the death. Kevin Doll declined to say whether Mr. Ayoub hanged himself or whom he told that he planned to commit suicide. The Florida Baker Act requires law enforcement to involuntarily commit anyone who threatens suicide. However, the Pasco County Detention Center policy called for them to be evaluated in-house. "If we removed every prisoner who made a threat, the Harbor (Behavioral Health Care Institute) would be full and the jail would be empty," Mr. Doll told the *Tampa Tribune*.

Assistant Public Defender Sanchez does not know what could have been done to save Norman Ayoub. "I never saw him as a danger to anyone but himself," she said. "I just don't think the criminal justice system is the place for" the mentally ill. ❑

Locked in Suffering: Kentucky's Jails and the Mentally Ill — A Follow-Up

by
Jim Adams

In a step to prevent jail suicides, a state commission yesterday (September 24, 2002) endorsed five changes in jail regulations — including a requirement that jailers report suicides and suicide attempts by inmates to the state. The state Jail Standards Review Advisory Commission also endorsed rules requiring suicide-prevention training for jail staff, more efforts to detect mental illness, and jail policies outlining how to respond to inmates who pose a suicide risk.

In February and March (2002) *The Courier-Journal* published a series of articles entitled "Locked in Suffering" that identified 17 suicides and two deaths of inmates in restraint in Kentucky's 85 county jails during a 30-month period, along with other shortcomings in the handling of mentally ill inmates [See the ***Jail Suicide/Mental Health Update***, Spring 2002, 11 (1): 10-12]. The newspaper found, among other things, that the state Department of Corrections did not track suicides in county jails, and that the state's elected jailers were not required by any law or rule to report suicides to state officials.

While jailers generally agree with reporting suicides to the state, some — including Harold Taylor of Owensboro, president of the Kentucky Jailers' Association — have opposed requiring jails to report suicide attempts. They argue that it would create a paperwork burden and additional liability for counties. State corrections and mental health officials have argued that to properly address the plight of mentally ill inmates, the state needs information on the number of jail suicide attempts.

After more than 30 minutes of debate yesterday, the commission, which oversees jail regulations, voted 9-4 to require reporting of jail

suicides and suicide attempts to the state Department of Corrections within 48 hours of their occurrence. Taylor and one other jailer, Louis Lawson of Hardin County, voted against the recommendation; a third jailer on the panel, Joey Stanton of Grayson County, voted for it.

Jim Dailey, a member of the national board of directors of the National Alliance for the Mentally Ill and president of the advocacy group's Louisville chapter, called the vote to report suicide attempts "progress for the mentally ill of our state."

The action by the 18-member commission is not the last word on the issue. New state regulations generally require two public hearings and approval of at least one committee of legislators, a process that can take six months.

In addition to suicide-prevention issues, *The Courier-Journal* series identified inadequate mental health training for jail staff, poor relationships between jails and community mental health agencies, and uncertainty over jails' level of responsibility for mentally ill inmates.

Since the series was published, much of the state's major groundwork on those issues has been overseen by a mental health study group, the "843 Commission" — formed by House Bill 843 in the 2000 General Assembly. Governor Paul Patton also included $550,000 over a two-year period in his current state spending plan for improved jail staff training in mental health issues, and in July ordered the standards commission to review regulations concerning "access to programs and mental health care for all persons confined in local detention facilities."

The standards commission yesterday received five general recommendations, all of which had been developed by an 843 Commission work group headed by Kim Allen, executive director of the Kentucky Criminal Justice Council. In addition to the one on jail suicides and suicide attempts, the recommendations called for regulations to require:

- At least four hours of training in mental health issues during the first year of employment for all jail staff who deal with inmates. In the series, *The Courier-Journal* reported that Kentucky had no requirement for suicide prevention or mental health training.

- A "policy, procedure or protocol" in each jail outlining how staff are to respond to inmates at risk of committing suicide.

- Screening of inmates as they come into jails to assess suicide risk, presence of any serious mental illnesses, and the risk of withdrawal from alcohol or drug abuse. Jail officers also would be required to record inmate behavior. The newspaper reported in its series that many Kentucky jails were using outdated or inadequate screening questionnaires.

- That the state Department of Corrections and the Kentucky Jailers' Association jointly develop a mental health training curriculum "to promote consistency and message." State officials and the association have been developing such a curriculum, which is scheduled to be unveiled in November.

Those four recommendations were endorsed with little or no dispute.

Another issue raised by the newspaper but not addressed yesterday was the fact that few Kentucky jails have contracts with local mental health agencies. Corrections officials have said a new regulation requiring such agreements has been discussed, and may be taken up by the standards commission at its meeting next month.

Yesterday, the major point of contention was the requirement that jails report suicide attempts. "It's hard to define what is an attempt or not an attempt," Taylor said. He argued that inmates often make suicidal "gestures," such as scratching an arm or tying a sheet to a bed, that are intended to manipulate jailers or get themselves moved from their cells. Often, Taylor said, "they're not really attempts."

Taylor also said that creating a report of suicide attempts "opens counties up to liability." Lawson, the Hardin County jailer, asked what the state plans to do with reports of suicide attempts, and wondered if the state would want a report every time an inmate threatens suicide.

Dr. Rick Purvis, a psychologist and director of the state Division of Mental Health, told the jailers that the state needs to know the scope of the problem. With such data, the state can better target where mental health services are most needed, state officials argued.

But the panel never defined the question Taylor raised about what a suicide attempt is. "It's more than a gesture and more than a threat," Hazel Combs, deputy corrections commissioner, said after the 9-4 vote. "It's an act."

Despite his opposition, Taylor said after the vote that he will not oppose the new rule as it works its way toward final adoption. Perhaps, he said, the information will eventually persuade the state to provide jailers with more aid in handling the mentally ill.

"The jails now are a dumping ground for people with mental health issues," he said.

*(Reprinted with permission from **The Courier-Journal** in Louisville, Kentucky, September 25, 2002, "Review Panel Endorses Regulations Intended to Curb Jail Suicides," by Jim Adams, Staff Writer. To obtain a copy of the entire four-part series of "Locked in Suffering: Kentucky's Jails and the Mentally Ill," contact **The Courier-Journal**, P.O. Box 740041, Louisville, KY 40201, (502) 582-4480, or visit their website: http://www.courier-journal.com/cjextra/locked).*

(Editor's Note: In a related item, a $200,000 settlement was reached recently over the jail suicide of Randy Johnson, who died in the Boyle County Detention Center in Danville in January 2001. Mr. Johnson's family had planned to file a lawsuit over his death alleging that he was not adequately observed by jail staff after he reportedly showed

*signs of suicidal behavior. Although legal counsel for both parties refused to discuss terms of the July 2002 settlement, The **Advocate Messenger** in Danville obtained the settlement agreement through an Open Records request. The settlement agreement releases those individuals and agencies named from any potential liability in the case, and states that nothing "shall be construed as an admission of liability on the part of any releasees; rather it is a compromise of disputed claims." One of the disputed claims, however, was that Randy Johnson's death was mentioned in another lawsuit filed in July 2001 by Ernesto Guerra, a former Boyle County Detention Center employee who claimed that discrimination based on his national origin and his criticism surrounding the handling of Mr. Johnson during initial confinement led to his dismissal as a jail deputy. In that lawsuit, Mr. Guerra stated he had allegedly warned a shift supervisor that Mr. Johnson "looked upset, was asking for help, and was a suicide threat." The warning was apparently ignored.)* ❑

PROJECT LINK: HOW ONE COMMUNITY COMES TOGETHER TO TREAT, NOT JAIL, THE MENTALLY ILL

They're among the toughest-to-treat patients: mentally ill people who have become entangled in the criminal justice system. For many, the final destination is a jail cell. Now Project Link, a program created by several Rochester community organizations and the University of Rochester Medical Center, is showing unprecedented success in treating this swath of patients, who often times bounce from jail to the hospital to the streets with no successful treatment.

"Jails and prisons have become the final destination for the mentally ill in America — -it's the most pressing issue facing psychiatry today," says psychiatrist J. Steven Lamberti, M.D., director of Project Link. "The Los Angeles County Jail has become the nation's largest mental institution. It holds more people suffering from severe mental illness than any hospital in the country. The problem has received a lot of attention, but there have been few proposed solutions. We've found one promising approach."

Project Link combines a number of innovative treatments, including a culturally diverse staff, close cooperation with the criminal justice system, a mobile treatment team, and a residence for patients with mental illness and addiction. Most important, several community-based organizations are partners, including Action for a Better Community, the Ibero-American Action League, Monroe County Clinic for Socio-Legal Services, Unity Health System, and the Urban League of Rochester. A representative from each is part of the project's management team, bringing together very different groups who share the goal of improving patients' lives.

"This program is a prime example of an innovative and much-needed service for persons with serious mental illness involved with the criminal justice system," says James L. Stone, Commissioner of the New York State Office of Mental Health. "Project Link has achieved significant reductions in jail and hospital lengths of stay and is making a significant contribution both to the individual clients and to the local mental health community," he said.

The program is aimed at people who have a severe and persistent mental illness and a history of involvement with the criminal justice system. Of the current participants, two-thirds never graduated from high school, one-third were homeless, and nearly half have felony convictions. About 85 percent have either schizophrenia or another psychotic disorder, and more than 80 percent reported using drugs or alcohol. Most are African-American or Hispanic men.

Project Link was recently recognized by the American Psychiatric Association as winner of the prestigious Gold Achievement Award for the most outstanding university-run clinical psychiatric program for the mentally ill in the country.

A recent study compared the experiences of 54 participants in the year prior to entering Project Link with their circumstances during the first year in the project. In the year before the program, these individuals spent an average of 109 days in jail and 105 days in the hospital. In Project Link, those numbers plummeted: Participants spent an average of just 40 days in jail and 14 days in the hospital. The average cost of caring for a participant fell as well, from $62,500 per person to about $14,500 per person, including the cost of the program. And the patients improved dramatically in their ability to take care of themselves: They managed money better, their personal hygiene improved, and they cut down their use of drugs and alcohol.

Very often, says Dr. Lamberti, mental health professionals, police and social service workers clash in their attempts to help such patients or protect society. "Before this program, it was as if these patients were lost in the Bermuda triangle: They bounced from jail to the hospital to the street with no hope of finding their way out."

To break the cycle, Dr. Lamberti initiated a program several years ago that evolved into Project Link. The first step was to hook up with key community-service agencies, whose leaders assumed a central role in the program. Thus the project is managed by Dr. Lamberti, director of the University's Strong Ties Community Support Program, along with five community leaders, one from each of the agencies directly involved. Through extensive dialogue, this culturally diverse team sets the project's policies, and the actual hiring of case advocates-the people closest to the clients-was put in the hands of the agencies.

"The diversity of the partnership and the diversity of the staff is what makes this work," says Gladys Santiago, a member of Project Link's management team and senior vice president of the Ibero-American Action League of Rochester. "Case managers need to know the culture and the language of the people they serve-it's a fact of life."

Robert Laird, who helps to manage the project as part of his job as deputy director for community services at Action for a Better Community, makes the same point. "We want to be sure we're

culturally representing the population we're serving," he said. "Cultural diversity is embodied in our recruitment process, from the directors of the program down to the case advocates." Mr. Laird says it's unique for community agencies to be part of a group working closely with the criminal justice system and the medical community. In particular, Project Link includes input from police, judges, and parole and probation officers, most of whom were skeptical when the program began.

Among Project Link's clients: a man who attacked his case manager, a man who set his house on fire after locking his family inside, as well as drug addicts, arsonists, and other felons. Rochester judges recognize many of these individuals, who had cycled through various programs and jails for years.

"There was lots of skepticism from potential funders, too," says Robert Weisman, D.O., the forensic psychiatrist who heads Project Link's mobile team that treats individuals in crack houses, homeless shelters, jails, and hospitals. "One visitor came through and said, 'Where I'm from, we lock these people up and throw away the key.' That summarizes what a lot of people think. But we've developed a system to treat these individuals successfully, and it saves taxpayers money in the process.

"Our clients are the folks who tend to fall through the cracks," Dr. Weisman adds. "We're the last stop for a lot of clients who have no other place to go. With traditional services, if they miss their first appointment, they're lucky to get a second one. Our program provides a third chance, a fourth chance, a fifth chance."

Much of the program's interaction with the criminal justice system happens through Dr. Weisman and a psychiatric nurse practitioner, Nancy Price, M.S., R.N., as well as Rudo Munondo-Ashton, M.S. R.N., project coordinator. The team tracks down and visits clients wherever necessary, sometimes treating them with medication, sometimes putting them back in touch with case managers. They're present if a client is brought in for breaking the law, and they're frequently in courtrooms and jails, talking with judges, public defenders, police, and lawyers.

The hands-on approach goes a long way toward bridging the gap between medicine and the criminal justice system. The team works closely with jail officials, often to make sure that clients agree to treatment as a condition of parole or probation. "Most treatment teams are based in the mental-health world, and clients disappear when they go into jail," says Dr. Lamberti, who is associate professor of psychiatry at the Medical Center. "Our team is part of both worlds; they're as comfortable in the jails as they are in the hospitals."

For more information about Project Link, contact either the University of Rochester, Department of Psychiatry, 300 Crittenden Boulevard, Rochester, New York 14642, or read "The Mentally Ill in Jails and Prisons: Towards an Integrated Model of Prevention," by J. Steve Lamberti, M.D., Robert L. Weisman, D.O., Steven B. Schwarzkopf, M.D., Nancy Price, M.S., R.N., N.P.P., Rudo Mundondo Ashton, M.S., R.N., and John Trompeter, C.S.W, in *Psychiatric Quarterly*, Spring 2001, 72 (1): 63-77. ❑

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.

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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, 2, 3, 4, 5, 6, 7, 8, 9 and 10)

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

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